Informed consent to undergo treatment for substance abuse: 
a recommended approach

Robert Walker, (M.S.W., L.C.S.W.)*, TK Logan, (Ph.D.), James J. Clark, (Ph.D.),
Carl Leukefeld, (D.S.W.)

Center on Drug and Alcohol Research, University of Kentucky, Lexington, KY

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Abstract

With more than 3 million persons receiving substance abuse treatment per year in the United States and with increasing interest in treatment outcomes, there is a need for closer attention to all aspects of the treatment process. However, minimal attention has been given to informed consent as a way of enlisting client engagement and active participation in treatment. Although there is some literature on informed consent in substance abuse research, the literature on informed consent to undergo substance abuse treatment is very limited. Incorporating informed consent into substance abuse treatment is recommended as part of motivational interviewing. Standard treatment consent issues include (1) the clinical characteristics of the problem, including diagnosis; (2) treatment recommendations; (3) the risks and benefits of treatment; (4) the financial costs of the intervention; (5) alternative services or interventions should a client refuse the recommended form of care; and (6) freedom to choose or refuse treatment. This article provides a background for informed consent procedures to facilitate client engagement in substance abuse treatment and suggests needs for future research on informed consent to undergo substance abuse treatment.

Keywords: Informed consent; Treatment consent; Treatment ethics; Substance abuse

1. Introduction

Substance-related disorders are prevalent in the United States population, with 14.6% of the population meeting lifetime criteria for substance use disorders (Kessler, Berglund, Demler, Jin, & Walters, 2005). A variety of treatment approaches and programs have been developed to provide services to the large number of individuals with substance abuse problems and co-occurring disorders (Galanter & Kleber, 2004). Most persons with substance use disorders eventually receive treatment, with between 52.7% and 76.9% making some treatment contact in their lifetime (Wang et al., 2005). In fact, the National Survey on Drug Use and Health estimated that approximately 3.3 million people 12 years and older were treated for substance abuse specifically in 2003; in addition, given the high co-occurring substance abuse and mental health problems, it is important to acknowledge that the 28 million adults receiving treatment for mental health problems may also have substance abuse problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2004).

The benefits and positive outcomes from substance abuse treatment have been extensively researched in large-scale studies (Hubbard, 2005). However, research suggests that differences in individuals’ recognition of their substance abuse problems and in their readiness for change are associated with variations in engagement during treatment and with posttreatment outcomes (Prochaska, DiClemente, & Norcross, 1992; Hubbard, 2005; Koenig, Harwood, Sullivan, & Sen, 2000). Treatment engagement may require the use of approaches that provide clients with information and the option to negotiate treatment along a continuum of commitment to change and within an environment of respect for clients and their contribution to treatment decisions (Kellogg, 2003; Rounsaville, Carroll, & Back, 2005).

One key to facilitating the process of negotiation and development of a collaborative alliance (Tatarsky, 2003) is for clients to engage in truly informed consent about...
treatment goals and approaches at the very outset of the process. However, although there is some literature on informed consent in substance abuse research, the literature on informed consent to undergo substance abuse treatment is very limited. In fact, the concept of informed consent appears to be almost totally lacking in clinical or behavioral health literature on substance abuse treatment and is virtually unmentioned in the literature on client engagement. In this regard, the increasing recognition about the importance of informed consent in mainstream medicine as articulated by the Institute of Medicine [IOM] (2001) has yet to achieve endorsement or even study in substance abuse treatment.

For example, an annotated bibliography of empirical research on informed consent identified 377 articles through December 1997; only 60 of these articles focused on mental health treatment, with slightly more than half (51.6%) focused on medication consent processes or consent to undergo psychiatric hospitalization whereas only 2 articles focused on informed consent in substance abuse treatment settings (Sugarman et al., 1999). The Hastings Center on Bioethics also published a library of articles on informed consent that included 766 citations. Fewer than 20 articles focused on mental health treatment and only 2 were related to substance abuse—1 of these was specific to informed consent with pregnant women about fetal exposure issues (Hastings Center, 2002). The National Library of Medicine published a bibliography of journal articles and books on research involving human subjects, including clinical trials; among the 1,378 citations on informed consent, not one title suggested substance abuse as a focus (Love, Thomson, & Royal, 1999). In their broader bibliography of 4,650 articles and books, there were two mentions of substance abuse-specific consent; both focused on research with prisoners. These reviews indicate that although a small literature may have emerged on informed consent to undergo treatment in mental health—particularly on clinical trial participation—there is a significant gap in the literature on consent processes and procedures in substance abuse treatment settings.

Thus, the purposes of this article were to present clinically relevant elements of informed consent, review general principles of informed consent in substance abuse treatment, and provide recommendations for integrating informed consent into substance abuse treatment. Although this article focuses on informed consent to undergo treatment, it is important to note that the discussion draws from the literature in three domains: (1) research, (2) treatment, and (3) clinical trials that involve both research and treatment participation by clients.

2. Overview of informed consent

Informed consent is the process by which clients are informed of their rights regarding treatment, as well as the benefits and risks of treatment. Informed consent is a legal and ethical duty in medical and psychiatric treatment and in research with human subjects (Berg, Appelbaum, Lidz, & Parker, 2001; Faden & Beauchamp, 1986). Research with human subjects is regulated by federal law (Code of Federal Regulations, Title 45, Part 46, 1994) and approved by local institutional review boards (IRBs) in universities and some agencies. The IRBs monitor the design and implementation of informed consent consistent with federal regulations. However, in clinical practice (apart from clinical trials research), there is no oversight or monitoring of client consent processes (Smith, 2001). Consequently, there is no clear standard on how informed consent should be incorporated into substance abuse assessment or intake processes. In addition, there is almost no information about the degree to which informed consent has been integrated into ongoing substance abuse treatment processes.

The concept of informed consent in treatment in general has distant roots in the medical ethics principle of beneficence, doing no harm, and helping patients (Chadwick & Mann, 1978; Faden & Beauchamp, 1986). However, the idea of actively obtaining patient involvement in treatment decisions is very recent. In the past, physicians often acted on their own authority without consulting with their patients about treatment decisions because they thought that this would be inimical to good patient care (Katz, 1999). Alternatively, they told very limited truths to patients about their conditions owing to therapeutic concern about how the information could be misused (Katz, 1999). The first evidence of informed consent as a major issue in American medicine was in the late 1950s and early 1960s (Faden & Beauchamp, 1986). In fact, although general medicine began incorporating informed consent in the 1960s, psychotherapy avoided the widespread use of informed consent until the Osheroff v. Chestnut Lodge case raised a serious question about the duty of providers to fully explain diagnoses and alternative treatments (i.e., risks and benefits) to clients (Bearhs & Gutheil, 2001; Klerman, 1990).

Informed consent in treatment developed on the heels of increased protections applied to research with human subjects. In fact, the 1947 Nuremberg Code (Emanuel, Crouch, Arras, Moreno, & Grady, 2003), the 1979 Belmont Report issued by the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research [NCPHSBBR] (1979), and the 1996 Declaration of Helsinki (Emanuel et al., 2003) articulated clear standards for obtaining informed consent from human research subjects before they are exposed to medical experiments or treatments that might result in harm.

Although informed consent has been described as being at the heart of the moral practice of medicine and treatment (Pellegrino & Thomasma, 1993), it may be perceived as less important in treatment settings than in research settings for several reasons. First, clinicians may have a limited understanding of informed consent and its ethical salience for clients with substance-related disorders. Second, clinicians may have limited training and organizational support for providing fully informed consent.
One barrier to a fully informed consent process in treatment settings is that clinicians may be biased in their perceptions of clients’ level of competence to make an informed consent to undergo treatment. For example, some clinicians might believe that the very nature of addiction threatens clients’ capacities to make informed treatment decisions (Sugarman, 1994), thus leading clinicians to treat clients without their informed consent. One author went so far as to explicitly suggest that clinicians should presume client incompetence to make decisions about treatment for opiate dependence (Charland, 2002). However, the literature on competence for informed consent does not specifically address substance abuse or dependence but focuses on severe mental illness, mental retardation, dementias, or other assessed impairments of cognitive capacity caused by chronic alcohol abuse (Griggs & Appelbaum, 1998; National Institute on Alcoholism and Alcohol Abuse [NIAAA], 2004). In other words, competence threshold standards target persons with sustained, severe cognitive, or other physical impairments (Elliott, 1997; Smith, Cutting, & Riggs, 1995). The criteria for client competence to make informed decisions include the ability to express choice, understand relevant information, appreciate the significance of the situation and the choices, and reasonably weigh options (Griggs & Appelbaum, 1998). The examples of situations for questionable competence presented by Griggs and Appelbaum (1998) and others (Appelbaum, 1997b; Workman et al., 2000) include dementias, brain injury, psychotic disorders, and mental retardation. These examples suggest more serious or more persistent cognitive impairments than are typical for substance-abusing individuals (absent significant cognitive impairment secondary to intoxication or to neurological damage from long-term use).

Clients with substance-related disorders might or might not meet cognitive impairment criteria depending on their overall clinical status, including toxicity, at the time of the assessment (Griggs & Appelbaum, 1998). In addition, when considering whether substance abuse clients are competent, the literature must be consulted for a comparison population. Clients with depressive disorders (except for psychotic depression) are typically considered competent to give consent to undergo research involving medical treatments (Appelbaum, Griggs, Frank, O’Donnell, & Kupfer, 1999; Elliott, 1997). Furthermore, selected patients with schizophrenia have been found competent to understand and retain informed consent information in some cases (Wisheing, Wisheing, Marder, Liberman, & Mintz, 1998); however, research subjects with mental illness, when compared with other medically ill subjects, are reported to have less understanding of consent information (Flory & Emanuel, 2004). There is no clinical or research evidence that substance abuse clients, even clients with co-occurring disorders, should be presumed incompetent to provide informed consent to undergo treatment. On the other hand, consent while intoxicated presents obvious problems and cannot be obtained until the client has detoxified.

In addition, it is unclear how well substance abuse clinicians are trained on fully informed consent or how much organizational support they have for fully informed consent procedures. Given that only 41.8% of substance abuse program counselors have masters degrees and only 74% have bachelor’s degrees (Mulvey, Hubbard, & Hayashi, 2003), formal education about informed consent as an ethical practice may be lacking. Even in the context of a research study where training on the research informed consent procedures is included, one study reported that few substance abuse clinicians had an adequate understanding of informed consent (Forman et al., 2002). Forman et al.’s study included 115 clinicians from 10 community-based addiction treatment organizations who were assessed for their pretraining and posttraining knowledge about the key elements of clinical research trials and human subjects protection. Less than half of the clinicians prior to the training had a clear understanding of informed consent (44%) whereas after training 24% still misunderstood fundamental elements about clients’ right to informed consent to participate (Forman et al., 2002). This misunderstanding may be related to an overall difference in the paradigm for understanding consent to undergo treatment, limited training, and/or lack of organizational support for consenting clients. In addition, in practice, informed consent may be viewed as merely a legal requirement to “sign a consent form” during intake. Organizational policies and procedures may override the importance of true informed consent procedures. More research is needed to better understand these issues among clinicians.

3. Fundamental elements of clinical informed consent

3.1. Research consent and treatment consent

Clinical trials research bridges the separation between consent to undergo research and consent to undergo treatment because participants agree to both research and treatment in clinical trials. In contemporary treatment ethics, obtaining informed consent from research subjects as well as patients and clients has become a routine expectation as a way to promote self-determination and autonomy (Acuff et al., 1999; Sugarman et al., 1999). The informed consent process in research has application to clinical practice because of experience with consent in clinical trials in various treatment settings. Although informed consent has received significant attention in research settings and has resulted in formal consent processes that are regulated by IRBs in universities, there is evidence that practices to protect substance abuse research subjects are far from complete. For example, McCrady and Bux (1999) surveyed 91 researchers with substance abuse projects including more than 19,000 subjects and found that 26% did not assess whether participants were competent to provide research consent. In addition, only 45% of researchers informed participants about their legal mandate...
to report confidential information such as child abuse (McCrady & Bux, 1999).

The Belmont Report highlights three critical guiding principles of informed consent: respect, beneficence, and justice (Brody & Waldron, 2000; NCPHSBRR, 1979). All three of these principles have corollary application to treatment practices. For example, respect implies that individuals be treated as autonomous agents. As a result of the post-WWII condemnations of Nazi research, the fundamental assumption of informed consent was that human subjects were no longer to be considered passive objects for scientific investigations or clinical trials but were to be seen as having an inviolable autonomy. Respect means that an individual participant’s rights and well-being must be respected and that the person is not a mere object in research. Respect means that the person must be considered an agent in the process. Beneficence implies a clinical concern and intent to improve clients’ health and well-being and means that clinical decisions should be shaped by that broad goal. Justice implies that all clients will receive fair and equitable treatment and treatment processes. Most importantly, for this article, the concept of respect grounds the idea of autonomy of the participant and autonomy forms an ethical base for informed consent.

Another ethical grounding for the consent processes described in this article is found in the Crossing the Quality Chasm: A New Health System for the 21st Century by the IOM (2001), which simultaneously recommends advances in the use of evidence-based interventions and in increasing the opportunity for patients to “exercise the degree of control they choose over health care decisions that affect them” (p. 6). The recommendation for more patients having greater control over their medical treatment suggests a similar need for autonomy of those who receive health, mental health, and substance abuse treatment services.

3.2. Autonomy

Faden and Beauchamp (1986; 1999) derived the requirements for informed consent from the principle of individual autonomy; however, they delineated two types of informed consent. In the first sense, informed consent is an actual authorization of a treatment by an informed and intentional patient. Individual agency is evident by a patient’s intention to receive the treatment. The second sense is a more institutional one that observes the correct legal means for obtaining consent from all patients who participate in institutional services and programs. The emphasis in this case is on meeting basic legal and licensure/accreditation standards. In this second sense, the consent signature can become the defining moment of the consent process. However, a signature may or may not satisfy the full meaning of the first sense, which goes directly to the agency and autonomy of the client. Consequently, clients should more than simply comply with treatment: they should actively authorize it as autonomous agents or take the opportunity to exercise control over the decisions (Faden & Beauchamp, 1999; IOM, 2001).

The standard informed consent process of requiring a routine signature on a document does not ensure fully shared decision making in which both the treatment provider and the client collaborate about a treatment plan (Epstein, Alper, & Quill, 2004). It can be argued that shared decision making is a necessary element in fully satisfying the requirement for client autonomy and that there is an abundance of information that can inform shared decisions about treatment although there is limited information about how to relate clinical evidence to specific clients (Epstein et al., 2004). Shared decision making involves a higher level of equity in the treatment planning process, requires a greater degree of client–clinician dialogue, and requires an elevated level of understanding by the client (Braddock, Edwards, Hasenberg, Laidley, & Levinson, 1999). It is the clear intent of the recent IOM recommendations for improved health care, and this process hinges on patients being given all the relevant information about their condition and treatment options (IOM, 2001).

Studies on the use of informed consent to undergo treatment in clinical practice find contrasting results. For example, Braddock et al. (1999), in a study on 1,057 audiotaped patient encounters among 59 primary care physicians and 65 surgeons, found that only 9% of the recorded clinical decisions met standardized criteria for providing clients with complete information for informed patient decisions. Another study reported that more of the simple and most basic treatment decisions were more often shared (17.2% of patients) as compared with intermediate treatment decisions (none met the criteria) and complex treatment decisions (0.5% of patients; Flory & Emanuel, 2004). A recent systematic review of interventions to improve research participants’ understanding of informed consent suggested that “more person-to-person contact, rather than videos or paper forms, may be the best way to improve understanding” (Flory & Emanuel, 2004, p. 1599). The failure to include patients in complex clinical decisions or to present information in a way that clients can understand and choose has been defined as a paternalistic medical practice that needs to be addressed through improved informed consent practices (Flory & Emanuel, 2004).

In searching for organizational support or guidance about the practice of informed consent, clinicians may turn to key clinical professions’ ethical codes or guidelines. A review of the ethical principles of the major professions that treat substance abuse suggests that there are very few common elements among the ethical codes and that the understanding of informed consent is uneven at best. Table 1 shows the basic provisions of each of the major substance abuse treatment organizations’ or professions’ provisions for informed consent.

The ethical principles for members of the American Society of Addiction Medicine (ASAM) state that “a physician shall respect the rights of patients” but do not
specify treatment informed consent and only refer to consent as authorization to disclose information when treatment is coerced by external agencies (ASAM, 2001). Psychiatric commentary on medical ethical principles includes a statement that psychiatric services are dispensed “in the context of a contractual arrangement between the patient and the physician” and that informed consent is to be “rigorously preserved,” but there is no reference to informed consent to undergo treatment as part of establishing the treatment contract (American Psychiatric Association [APA], 2001). Informed consent is specifically referenced about presenting a patient to a scientific meeting (APA, 2001). The principles do include a provision for describing limits of confidentiality to a patient before conducting a court-ordered evaluation (APA, 2001). The National Association of Social Workers’ (NASW) code of ethics states that services should be provided “only in the context of a relationship based on informed consent” (NASW, 1999). Although the code elaborates several aspects of informed consent, it does not specify all the key elements of informed consent as discussed further on in this article. The American Psychological Association [APA] provides detailed guidance for informed consent to undergo assessment, treatment, and research, including provisions for assent among persons who have limited ability to provide consent (APA, 2002). The consent to undergo treatment includes some of the key elements of a full consent process, such as describing the course of treatment and fees (APA, 2002). The National Association for Addiction Professionals’ ethical standards do not use the term “informed consent” but states that a “NAADAC member shall inform the client and obtain the client’s agreement in areas likely to affect the client’s participation including the recording of an interview, the use of interview material for training purposes, and/or observation by another person” (National Association for Addiction Professionals, 2004). This use of consent is clearly not an informed consent to undergo treatment but to disclose information. The SAMHSA’s ethical principles include provisions for respect for persons and respect for individual self-determination that ensure that participants are “adequately informed about and give consent to proposed interventions and evaluations” (De Jong & Reatig, 1998). SAMHSA also calls for disclosing “all relevant and foreseeable benefits or burdens or risks or harms in a manner that promotes comprehension and cooperation” (De Jong & Reatig, 1998). Lastly, the NIAAA has an educational module for social workers that applies the NASW’s code of ethics to the treatment of alcohol use disorders with a very elaborate discussion of informed consent to undergo treatment (NIAAA, 2004). This training module specifies the elements of an informed consent to undergo treatment, including all the elements discussed further in this article.

4. Informed consent in the context of substance abuse treatment

Substance abuse treatment, unlike most medical treatments, has fewer specific pharmacological or surgical events
that call for specific consent. Mental health treatment involving medications is more likely to trigger an informed consent when medications are prescribed. However, unlike many types of mental health treatment where medications become a focus early in the process, substance abuse treatment (after detoxification) more likely involves psychosocial and talk therapies. This means that informed consent about potentially intrusive medical procedures such as blood tests or brain imaging and consent to undergo medication may be rarely used in substance abuse treatments. Consent to undergo specific medical interventions may have greater salience for clinicians, and the risk/benefit aspects of these procedures may be clearer than those associated with talk therapies. Defined medical procedures can be attached to consent events rather than consent processes that can stretch out over time (Lidz, Appelbaum, & Meisel, 1988). In fact, the lack of clear and distinct substance abuse treatment procedures may account for many of the difficulties in implementing informed consent. However, many substance abuse programs require urine screens that often have greater significance than other laboratory tests in a health care setting (e.g., they can result in probation revocation). The presence of urine screens should provide a clear and definable event for informed consent to undergo treatment.

4.1. Informed consent and clinical processes

In the absence of many signal events for consent, a more graduated consent process may be more congruent with clinical processes. In fact, there may be ambiguity about the actual starting point for substance abuse treatment because substance-abusing individuals may be at different stages with regard to their awareness of problems and their desire to engage in treatment for their problems (Tatarsky, 2003). A stepwise graduated consent process may be indicated in substance abuse treatment—an approach that builds on the transtheoretical stages of change model as described by Prochaska et al. (1992). The transtheoretical stages of change model describes a continuum of awareness of substance abuse problems and the need for treatment beginning with precontemplation (where individuals have no awareness of a problem and see no need for treatment) and leading to contemplation (where a problem is beginning to be recognized), preparation (where steps for change are being examined), action, and then maintenance of treatment gains (Prochaska et al., 1992). Informed consent may need to be implemented in a stepwise manner consistent with clients’ stage of problem awareness and readiness to change.

Informed consent to undergo treatment can be titrated to each client’s stage of problem awareness and recognition of the need for change with the use of the transtheoretical model. Clients entering substance abuse treatment may have limited awareness of their substance abuse problems and may be at the precontemplation stage in which they are unprepared for a full discussion of the consequences of substance abuse or dependence or the need for treatment. Traditionally, clients’ lack of awareness of substance abuse problems has been viewed as denial, but the stages of change approach views this as precontemplation from which clients can progress to greater awareness with additional information. Instead of interpreting clients as refusing to admit a problem, it may be useful for providers to first consider the clients’ lack of information about substance abuse and its harmful effects (Margolis & Zweben, 1998). Informed consent can provide clients with information about substance abuse problems and treatment in a gradualist way. In addition, consent processes can help clients move into different stages of change and/or different levels of treatment and can, in fact, continue throughout the treatment process.

4.2. Consent process versus consent event

The use of informed consent around the stages of change builds on the description of a consent process as opposed to a consent event set forth by Lidz et al. (1988). A consent event is the medicolegal requirement to obtain a consent signature from a patient or client before implementing a treatment regimen (Berg et al., 2001; Faden & Beauchamp, 1999; Lidz et al., 1988). Typically, the consent event occurs at the beginning of treatment. However, as seen above, client awareness and motivation may change significantly throughout the treatment episode and clinicians should recognize these changes by updating the informed consent to incorporate self-efficacy and client autonomy. Thus, the consent process, as implied in the stages of change model, continues throughout the treatment episode and becomes a “facet of all stages of medical decision making” (Lidz et al., 1988, p. 1386). Unlike abstinence-only approaches, gradualist and harm reduction approaches such as motivational interviewing require a collaborative treatment process between the provider and the client throughout the entire treatment episode (Miller & Rollnick, 1991, 2002; Tatarsky, 2003). As the treatment focus changes with client progress through the stages of change, renewed consent to undergo treatment is indicated.

In substance abuse treatment, the consent process might change as clients move from detoxification to a longer-term residential treatment or when beginning intensive outpatient treatment after detoxification. An informed consent process for clients with substance-related disorders means that treatment providers would talk with clients at each juncture in treatment when the focus or modality of treatment is likely to change. Although signatures might not be required at these transitions, clients should agree in principle with each change of focus or modality of care. This would be consistent with the IOM’s recommendation for patient control of treatment decisions that affect their lives (IOM, 2001). Moving into residential treatment can
result in losing employment—a cost of treatment that should be considered.

5. Elements of informed consent in substance abuse treatment

When introducing a continuous and evolving consent process, the standard treatment consent issues include (1) the clinical characteristics of the problem, including diagnosis; (2) treatment recommendations; (3) the risks and benefits of treatment; (4) the financial costs of the intervention; (5) alternative services or interventions should a client refuse the recommended form of care; and (6) freedom to choose or refuse treatment. All of these elements are part of a commitment to voluntarism in participation, an often overlooked issue in treatment (Roberts, 2002a). In fact, voluntarism is essential to fulfilling the idea of informed consent although the understanding of voluntarism must be adjusted to clients’ clinical and cultural circumstances (Roberts, 2002a).

5.1. Informing clients about their clinical characteristics and diagnosis

Substance abuse clinicians who are implementing informed consent should share their assessment findings with clients. This use of feedback information is consistent with the motivational interviewing approach (Miller & Rollnick, 1991; 2002). It is an ethical obligation for clinicians to share information because withholding information could jeopardize a client’s health and welfare and would have the effect of diminishing the opportunity for control over any treatment decision. Discussing the assessment findings and diagnostic impressions may help clients identify issues that could facilitate further progress toward change. When sharing diagnosis or other clinical characteristics, providers should impart information that is understandable, recognizing that each client’s level of understanding, general literacy, and health literacy may be very different. Furthermore, clients may not welcome being in treatment if they have been referred by the criminal justice system and information about the treatment process and how it relates to the courts may be important in clarifying the distinct roles of treatment providers and the courts. Later on in treatment, criminal justice-referred clients may have very different needs for information about treatment with a greater focus on recovery options.

Another advantage of providing consent incrementally during treatment is that clients may be initially overwhelmed by excessive diagnostic and treatment information while their understanding may improve as they progress through the stages of change. This suggests a need for providers to continually communicate additional information that can be used in making further treatment decisions.

5.2. Treatment recommendations

Before initiating treatment, clinicians should describe the recommended treatment intervention in terms of client time commitments and the specific ways that interventions are to be implemented (Berg et al., 2001; Reamer, 1987). This discussion could include describing treatment sessions, the duration of treatment sessions, the number of weeks of treatment, who the clinicians will be and their qualifications, the empirical support for recommended interventions, and the basic expectations for client participation. In certain programs, this may also include an expectation of client commitment to abstinence.

In treatment settings where there is a one-size-fits-all program, consent may be reduced to a “take it or leave it” proposition, with limited room for clients’ consent to discrete treatment decisions. This uniform approach flies in the face of individualized treatment planning and client- or patient-centered rather than program-centered treatment (IOM, 2001). In fact, it might be argued that implementing informed consent might be a way to curb the tendency toward a one-size-fits-all treatment.

5.3. Informing clients about the risks and benefits of treatment

After describing what a treatment involves, clinicians should describe the potential benefits and risks of the recommended interventions. This is a clear and standard practice when medication is prescribed because pharmacological side effects must be discussed with patients. However, it is less clear with talk therapies. Given what has been learned about the outcomes of evidence-based practices, clients can be informed about the risks and benefits of talk therapy as well as medical treatments. Clients are entitled to research-based treatments (Thyer & Myers, 1998), and reviewing evidence-based approaches can be an asset to the treatment process (Reamer, 1987). In addition, treatment does not work for everyone and clients should be apprized of this information. Even well-tested approaches will be only partially effective or even ineffective for some clients.

In addition to negative treatment outcomes, there are other risks that should be reviewed with clients before substance abuse treatment begins. The review of medical and surgical risks carries a high degree of specificity because the exposure to interventions can have direct and negative consequences (Berg et al., 2001). The risks from verbal therapies are less direct but important. Most of the risks from participating in substance abuse treatment involve confidentiality problems. Although confidentiality has been a hallmark of counseling professions and psychiatry, current legal mandates create numerous exceptions to absolute confidentiality, and clients should be informed about these exceptions before they disclose sensitive personal information. For example, child abuse
must be reported. This is not an unexpected risk given the prevalence of child abuse and interpersonal violence victimization experiences among substance-abusing individuals (Logan, Walker, Cole, & Leukefeld, 2002; Logan, Walker, Jordan, & Leukefeld, 2005). In addition, most states require the use of a Tarasoff duty to warn and/or protect intended victims when clients threaten to harm or kill others (Manhal-Baugus, 1996). Fully informing clients about confidentiality and other treatment risks as well as benefits and allowing clients choices may facilitate client recovery by recognizing and highlighting the importance of their contributions to treatment and recovery.

5.4. Financial costs of treatment—Informing clients about fees, appointments, cancellations, and program rules

Substance abuse clinicians should carefully describe fees for services, how insurance or other third-party funding covers costs, data collection procedures for insurance and for agency requirements, appointment compliance requirements, and cancellation policies. These business items should be carefully explained before clients enter treatment so that their decisions are made with a clear understanding of costs and compliance issues. In addition, many substance abuse programs (particularly residential programs) have extensive rules and regulations about client behavior, constraints on privacy, communication with friends and family, and other behavioral rules while in treatment. These should be discussed fully before clients enter the program.

5.5. Alternative services and/or interventions

Among the most important but seldom practiced elements of fully informed consent is the description of alternative treatments so clients can make an informed choice. Providers who are locked into single models of treatment, such as some residential programs that require client adherence to a uniform protocol, may not be able to offer alternative treatments within their own facility. In these cases, providers are ethically required to offer information about alternative providers. Providers in closed treatment networks may have greater difficulty offering alternative treatments; however, choices can include different modalities of care or alternative clinicians within the same network or program. Recent federal law has instituted freedom of choice, including freedom to choose faith-based providers for substance abuse treatment. More importantly, clinicians may need to better understand the science of substance abuse treatment to competently describe the spectrum of treatment approaches and their possible outcomes (Appelbaum, 1997a; NIAAA, 2004).

5.6. Freedom to choose and refuse treatment

Substance abuse clinicians should respect the right of clients to choose less effective treatments and even their right to refuse treatment altogether. The recognition of clients’ right to refuse treatment does not necessarily mean that their better interests are served. Indeed, clients’ health status may be poorly served by exercising their right to refuse treatment (Kapp, 1994). Client refusals should not be met with punitive responses or a professional refusal to provide services in the future when a client reapplies. In addition to having the right to refuse treatment, clients have the right to withdraw consent to undergo treatment after having given it. Of course, many (often a majority) of patients in a treatment program may have been coerced into treatment by an external authority such as the criminal justice system. Such clients who wish to withdraw from treatment are nonetheless able to do so—but the program has the obligation to inform them of the likely legal consequences of that decision.

6. Summary and discussion

This article argues that informed consent in substance abuse treatment settings has received limited attention but is nonetheless important on ethical grounds (see IOM, 2001) and is potentially important in the development of more engaging and lasting therapeutic relationships. Two main barriers were discussed with regard to informed consent within treatment settings. First, clinicians may have a limited understanding of the ethical salience of informed consent for clients in substance abuse treatment. Second, clinicians may have limited training and organizational support for a fully informed consent process. This article also suggests that a good consent procedure includes respect for autonomy and informed consent as an ongoing process throughout the treatment experience for clients. Finally, this article suggests that informed consent within substance abuse treatment settings, at a minimum, should include providing information to clients about their clinical characteristics and diagnosis, treatment recommendations, risks and benefits of treatment or the particular recommended treatment, costs of treatment and program rules, alternative services and/or interventions, and the freedom to choose and refuse treatment.

Informed consent to undergo treatment in behavioral health has both advocates and critics. Some have argued for full disclosure of treatment options and full patient consent (Klerman, 1990) whereas others have seen problems with this approach (Bearh & Gutheil, 2001; Stone, 1990). Increasing liability for failure to provide full disclosure of risks of treatment may contribute to the interest in informed consent (Acuff et al., 1999; Bearh & Gutheil, 2001). However, there is very limited literature on the applications of informed consent in substance abuse treatment, including the issue of competence (Roberts, 2002b).

The limited attention to informed consent and client autonomy in substance abuse treatment literature may originate from fundamental beliefs about addiction and
denial or may be related to beliefs about the clinical futility of truly engaging client consent to undergo treatment given the presence of denial, distorted consciousness caused by acute and chronic intoxicating substances, and even client deception about substance use. The competence of substance-abusing individuals to give informed consent to undergo treatment may be a valid concern; however, it should be emphasized that there is very limited research about substance-abusing individuals’ competence to give consent to undergo either treatment or research.

The idea of highlighting clients’ autonomy in substance abuse treatment may seem in conflict with the 12-step orientation, which at the outset asks clients to admit to being powerless over their addiction. Emphasizing autonomy may appear incongruent with the aims of the first step. However, educating clients about their addiction and the many ways that can be used to recover from it is consistent with a 12-step approach, and informed consent can become part of self-help-oriented treatment programs.

There has been a call for more science-based substance abuse treatment models (Backer, David, & Soucy, 1995; Brown & Flynn, 2002; Leshner, 1997). In addition to using research-based interventions, there is a need to use informed consent to undergo treatment in substance abuse programs to parallel the emphasis on informed consent in research protocols. Clinicians may not trust clients’ ability to make informed decisions about their treatment. However, to date, no compelling evidence suggests that substance-abusing clients cannot make informed decisions about treatment. In the absence of clear incompetence to give consent, clinicians have an ethical obligation to use informed consent. In particular, clinicians should provide more detailed and careful explanations of treatment benefits and risks, as well as all known treatment options. This is true for all clients, including those referred by the criminal justice system.

The newer paradigm for medical treatment includes a patient–physician conjoint planning team in which “patients should have unfettered access to their own medical information and to all clinical knowledge” (IOM, 2001, p. 62). This approach should be considered in substance abuse treatment as well. Out of respect for recovering persons, clients should be given all the information that they need to use treatment services to their greatest benefit. Part of the IOM’s point is that the evidence-based practices, by themselves, are not the end all. What is needed is the sharing of all that is known about these services in the context of each patient and his or her values (IOM, 2001). “Evidence-based practice is the integration of best research evidence with clinical expertise and patient values [emphases added]” (IOM, 2001, p. 146). In other words, the expert use of evidence-based practices draws in clinical knowledge and client participation as well. Informed consent is the ethical mechanism to help build that collaboration between providers and clients.

There are several important limitations or barriers to the implementation of informed consent. For example, it is unclear how informed consent can be used in health maintenance organizations where providers are limited to presenting the approved range of treatment options, and this condition may “compromise” informed consent owing to restricted options (Chambliss, 2000, p. 44). However, others have argued that informing clients about plan limitations is an important part of contracting for providing care (Mechanic, 1994). In addition, intake and admission processes may be very data collecting intensive and clinicians may view informed consent as another bureaucratic intrusion into treatment time. Although these limitations are clear, this article has described advantages to incorporating the ethical practice of informing clients about their disorders, treatment needs, and alternatives as components of the informed consent process.

More research is needed to better understand how clinicians understand informed consent and how they actually implement it. For example, it is unclear whether the absence of informed consent in clinical practice affects the implementation of research-based interventions that have been tested under thorough consent conditions. Failure to provide informed consent to undergo treatment may affect client engagement and the effectiveness of even evidence-based interventions in real-life practice settings. Furthermore, there is no research to actually describe the practice of informed consent in substance abuse treatment initiation or throughout the treatment process. Informed consent remains a part of the black box within which treatment occurs, but about which not much is known. Future research should examine whether a more complete practice of informed consent, particularly very early in the intake process, could positively affect client engagement and retention by culling out those who are not ready for change and actively engaging those who are. Research should also examine competence to give consent among clients with substance use disorders.

In the context of increasing demand for services and insufficient resources, the application of truly informed consent might remind clinicians of the importance of individual needs and client contributions to treatment. Informed consent to undergo treatment might interrupt the tendency toward a cookie-cutter approach that gives every client the same program content and that defines success as mere compliance and program completion. Informed consent also requires greater clinical focus on a person as an active agent of treatment rather than as a passive recipient of a standard protocol. In addition, the genuine practice of informed consent might also force a decisional issue for clients about whether to enter treatment. The cookie-cutter approach involves presumptive treatment, and clients’ only choice is compliance or dropping out. Informed consent could move that choice into a proactive pretreatment decision to either participate or not and thus reserve scarce treatment slots for clients further along in their readiness to change. As such, informed consent could benefit both clients and providers.
References


