ETHICAL BOUNDARIES, LEGAL PROTECTIONS, AND PRACTICAL STRATEGIES FOR NAVIGATING DUAL RELATIONSHIPS IN RURAL SUBSTANCE USE DISORDER CARE

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OVERVIEW

Dual relationships or multiple relationships arise when a healthcare provider interacts with a patient outside of a professional setting.[1] These can often be unavoidable in rural communities due to the small population size and limited number of providers. These relationships have the potential to complicate interactions between healthcare providers and challenge treatment decisions. Yet they may also increase trust and comfort between providers and their patients. A common example is the "word-of-mouth referrals." When a trusted source, like a friend or family member, recommends a therapist, it can make it easier to start building a good working relationship. Such referrals can help establish trust between a patient and provider.[1] However, in small, interconnected communities, strict avoidance of dual relationships can appear dismissive or uninvested, highlighting the importance of thoughtfully managing boundaries rather than attempting to eliminate multiple relationships altogether.[2] The purpose of this policy brief is to clarify the ethical, legal, and clinical challenges posed by dual relationships in rural substance use disorder (SUD) care and to recommend practical strategies that help providers and organizations maintain professional boundaries, protect confidentiality, and improve care quality in small, interconnected communities.

WHAT IS A DUAL RELATIONSHIP?

Dual relationships may take the form of a provider being a patient's neighbor, family member, or community member. In urban healthcare, dual relationships are less likely because of the larger population and greater number of available providers. There are more individuals with whom to interact, thereby decreasing the potential for dual relationships. As such, in rural communities, it is more likely for a healthcare provider caring for a patient experiencing SUD to interact with them outside of the professional setting. This prompts the need for delicate balancing of these dual relationships as they carry both potential benefits and risks.

Table 1. Benefits and Risks of Dual Relationship in Rural Healthcare for Substance Use (SU) Care.

Benefits of Dual Relationships	Risks of Dual Relationships
Cultural & Contextual Insight for Care Delivery: Knowing local norms, family dynamics, and resource gaps helps providers tailor overdose-prevention plans that work in practice.	**Biased Clinical Judgment:** Prior knowledge can lead to assumptions that skew assessment, diagnosis, and/or prescribing decisions.
Strong Therapeutic Alliance: Shared community identity can augment rapport and boost treatment adherence.	**Patient Reluctance to Disclose:** Fear that "everyone will find out" may cause under-reporting of substance use, mental-health symptoms, or legal issues.
Enhanced Trust: Relationships outside of the professional environment can increase trust between patients and providers within the professional setting.	**Dual-Role Conflicts:** Situations where the provider also serves as a school board member, landlord, or law-enforcement volunteer can create competing obligations and legal risk.

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WHAT ARE SOME ISSUES TO CONSIDER ABOUT DUAL RELATIONSHIPS IN RURAL HEALTHCARE?

Navigating dual relationships in SUD care may add additional complexity due to clinical, ethical, and legal considerations. People may use or misuse substances in social settings, which could influence a provider's understanding of the patient and the severity of substance use. According to Davis and Roberts, **familiarity with patients outside of professional settings may lead health care providers to be less thorough in history-taking** due to assumptions that they already understand the patient's full story.[3] A thorough understanding of a patient's substance use history supports the development of effective, patient-centered treatment plans. Objective and non-biased history-taking is crucial to the well-being of the patient and requires continuous self-evaluation by the provider. When a provider knows a patient outside of professional settings, they may allow their outside perceptions to lead them to make assumptions about a patient's history or desired treatment.[3]

Perhaps the biggest concern with multiple relationships is a violation of professional boundaries. This is why the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) articulates that when multiple relationships are unavoidable, as can frequently occur in rural communities, it is of the utmost importance for professionals to take extra care to ensure their judgment is not impaired and that patients are not placed at risk of exploitation.[4] In accordance with these principles, Palomin et al. promote early and repeated discussion within professional spaces about the safest management of these relationships in addition to formal training tailored to the subject.[2] Unfortunately, much of the training that currently exists does not translate well to rural dynamics, as it was developed in relation to urban environments.[1] To support ethical boundary navigation in small or rural communities, providers should engage in client-centered communication that openly acknowledges the potential for dual roles when they arise.[5] Doing so creates an opportunity to establish clear expectations, center the patient's perspective, and proactively address confidentiality concerns. To protect patient privacy, uphold ethical standards, and maintain professional boundaries, providers should implement the following practices:

- Implement proactive boundary management in incidental public encounters common in small and rural communities.
- Default to non-acknowledgment in public unless patient consent is clearly given.
- Engage in private discussions about public interactions, support confidentiality, trust, and ethical practice.
- Provide clear documentation of consent and revisit the topic periodically to help protect both patients and providers.

LEGAL IMPLICATIONS

Regarding the law, patient confidentiality has been reaffirmed by the Confidentiality of Substance Use Disorder Patient Records regulations at 42 C.F.R. Part 2 (Part 2). As of February 8, 2024, these regulations extend protection to records containing patient identity, diagnosis, prognosis, or treatment information when such records are created or maintained by programs or activities related to SUD education, prevention, training, treatment, rehabilitation, or research that receive federal oversight or support.[6] Any program that meets these qualifications is considered a "Part 2 Program." These protections were designed to relieve concerns of discrimination and fear of prosecution that may deter people from pursuing SU care. Not all health care organizations or programs are considered federally assisted "Part 2 Programs,"so it's important to determine whether an organization falls within this designation. Privacy and confidentiality laws apply directly to dual relationships, as protecting privacy and confidentiality in a community may be challenging. Clear processes and procedures ensure providers can respond to patients in the community and help manage any challenges. Potential misunderstandings in the community decrease by informing patients about these processes.

WHAT ARE THE IMPLICATIONS FOR SUD CARE IN RURAL ARIZONA?

Arizona is home to many communities in which multiple relationships are prevalent. The Arizona Behavioral Health Workforce Report estimates 40% of Arizonans, roughly 2.85 million people, live in a mental health professional shortage area (HPSA), including rural counties such as Apache, Navajo, Graham, and La Paz.[7] While dual relationships are already prominent in rural communities, their prevalence is further exacerbated by workforce shortages. There exists no official state or federal registry of 42 CFR Part 2 programs for Arizona, so an exact facility count is unavailable; instead, Part 2 status depends on whether a program is 'federally assisted' and provides SUD diagnosis, treatment, or referral. Given that Arizona's SUD treatment and prevention infrastructure, which includes many Medicaid-funded outpatient programs, opioid treatment programs, and block grant-supported services, relies heavily on federal funding, a substantial proportion of rural SUD providers are likely to fall under Part 2. In such Arizona communities, where the same limited number of Part 2-covered clinicians serve as neighbors and community members, **dual relationships are not only common but structurally embedded.** Thus, client-centered conversations about boundaries and confidentiality represent a critical ethical pillar rather than an optional enhancement. Providers can lean upon state-level ethical guidance, such as the Arizona Board of Behavioral Health Examiners' Best Practice Guide for Avoiding Conflicts of Interest and the accompanying guide on Establishing and Maintaining Boundaries with Clients, both of which provide a framework to identify the formation of a dual relationship or conflict of interest.[8]

THE RURAL HEALTH TRANSFORMATION PROGRAM: HOW IT CONNECTS TO DUAL RELATIONSHIPS

The recently passed H.R. 1 One Big Beautiful Bill Act (OBBBA) includes a new Rural Health Transformation Program (RHTP) that has awarded the state of Arizona roughly 167 million dollars each year for the next five years. These funds are expected to support initiatives that strengthen rural health systems, expand behavioral health services, modernize health technologies, and improve workforce capacity.[10] According to priority goal II, behavioral health and SUD grants are to comprise 6% of the total annual budget. These funds are distributed at the discretion of Arizona's Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS). In order to promote proper boundary management, appropriate navigation of dual relationships, and better outcomes for individuals experiencing SUD and their providers, this brief can help inform the allocation of resources that support ethical practice, workforce sustainability, and effective behavior health service delivery in rural communities as RHTP activities are implemented.

RECOMMENDATIONS

Key takeaways for Arizona healthcare organizations and providers:

- Ensure that all rural SUD programs provide structured, recurring training on managing dual relationships and conflicts of interest in small communities, including case-based scenarios that integrate 42 CFR Part 2 privacy obligations with client-centered communication about boundaries.
- Participate in or establish a standing rural behavioral health peer-consultation group, hosted through an existing entity such as a state organization or rural health center, to review de-identified cases involving dual relationships and 42 CFR Part 2 challenges, share boundary-setting language, and develop sample policies tailored to small communities.
- Rather than avoiding dual relationships altogether, navigate them via maintaining professional boundaries, referring to state-level ethical guidance, and consulting other trusted professionals for support. Utilize open, transparent client-centered communication consistently, and, if necessary, transfer care of a patient if a dual relationship creates a conflict of interest or impairs judgment.
- Incorporate explicit expectations for client-centered boundary management and dual-relationship documentation into organizational policies, supervision practices, and quality improvement metrics for rural SUD programs.

State Agencies and Policy Makers

- Allocate grant funding for rural recipients to develop and implement structured, recurring training on managing dual relationships in small communities covering 42 CFR Part 2 privacy obligations.
- Dedicate a portion of the RHTP funding to provide a permanent grant to a state organization to host and moderate a statewide rural behavioral health peer-consultation group to ensure not only establishment but sustainability of the group and its services.
- Incorporate “Boundary Management Plans” as a required component of the grant application process for RHTP funds to ensure organizations have plans for dual-role navigation management.
- Modernize tele-health infrastructure to increase the availability of Health Insurance Portability and Accountability Act[BR17.1] (HIPAA) and Part 2-compliant tele-health platforms in rural communities to provide individuals with needed services while mitigating the opportunities for dual-relationship conflict.

ADDITIONAL RESOURCES

Listed below are further resources that detail the intricacies of dual relationships within rural communities, the contexts within which they exist, and methods for approaching them. Readers interested in additional information may explore the following resources:

Handbook for Rural Health Care Ethics: A Practical Guide for Professionals

The Ethics of Overlapping Relationships in Rural and Remote Healthcare. A Narrative Review

Navigating Dual Relationships in Rural Communities Research Article

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