Ethical Issues

Ethics is a term that can imply lofty, philosophical discussions, far removed from the everyday world. In reality, workers in the substance abuse treatment field are constantly faced with ethical dilemmas on an individual as well as a societal level. Ethics is an intellectual approach to moral issues, a philosophical framework from which to critically evaluate the choices and actions people take to deal with various aspects of daily living (National Association of Social Workers [NASW], 1997).

Working in the substance abuse treatment field presents dilemmas relating to personal beliefs, judgments, and values. The history of how society views persons with addictions is fraught with emotion, misperceptions, and biases that have affected the care of drug abusers. For example, it is not unusual in a health care setting for a patient to be perceived negatively just by being labeled a drug abuser (Carroll, 1995). Because of the highly charged emotional nature of the substance abuse treatment field, providers should possess the tools to explore ethical dilemmas objectively. By doing so, and by examining their own reactions to the situation, providers can proceed with the most ethical course of action. (See Appendix E for the Federal and State codes of ethics for programs treating HIV-infected substance-abusing clients.) Chapter 9 discusses the legal constraints, obligations, and options that provide the framework within which ethical issues must be decided.

Ethical Issues for Treatment Providers

The Ethics of HIV/AIDS

Taking the most ethical course of action becomes even more complex when HIV/AIDS is thrown into the mix of concerns that the client may present. HIV/AIDS has its own unique ethical issues. Because HIV can be transmitted through sexual activity and by sharing drug equipment, it evokes significant personal feelings and judgments in the general public, as well as in health and social service providers. Advocates for persons with HIV have fought for years to maintain confidentiality, avoid mandatory reporting, and ensure access to care for those with the disease. Because of the labels "drug abuser" or "homosexual" and the fear of a backlash toward people with HIV, advocates have been pushing strongly toward preventing discrimination. This has led to creating safeguards to protect these individuals from discrimination in health care, employment, housing, and other services.

Ethics on Micro and Macro Levels

Ethical issues are both personal (micro) and societal (macro) in nature. There is an ongoing struggle between legislating morality for the "public good" and fighting to retain an individual's right to autonomy. It is the intense emotional nature of such concerns that takes an issue from a personal level to a societal level.

Syringe exchange programs (SEPs) are a good example of such ethical dilemmas. While

the Secretary of the U.S. Department of Health and Human Services announced in 1998 that a review of scientific reports indicated that SEPs can be an effective component of a comprehensive strategy to prevent HIV, the restriction on Federal funding for SEPs has not been lifted. At issue is whether giving out clean syringes may sanction or encourage illegal drug use (see Chapter 4 for more information).

Alcohol and drug counselors may find that their time is spent not only sorting out client-level ethical dilemmas, but also dealing with societal-level dilemmas. This could involve advocating for legislation that protects the rights of clients or adapting to the impacts of a policy that will further restrict a provider's ability to intervene effectively with a client group.

Balancing Personal and Professional Standards

Alcohol and drug counselors must balance what is right for them personally with what may be right based on professional standards. Substance abuse treatment professionals who are social workers, for example, should be familiar with the NASW Code of Ethics and may have to reconcile personal beliefs with the profession's code. There also may be agency standards that conflict with an individual's personal beliefs. In either case, there is a constant need to weigh what may "feel right" personally with the standards and policies of the environment and profession.

Perhaps the most difficult dilemma occurs when there are conflicts between the clinicians's values and the client's behaviors. Professionals know that if a client threatens suicide or homicide, there is a duty to report. But most of the daily concerns that arise are not so simple. Ethical issues come up in numerous, seemingly insignificant ways. Did the client understand what the release of information stated, or did she rush so that the provider could make the next appointment? Did the clinician listen to what the client said about her culture, and how the treatment plan would not work because it was not created in a culturally competent manner? Was information about the client shared with another helping agency, even though she did not give a release to that particular agency? These are the kinds of issues that arise every day, affecting client care and reflecting on one's status as a clinician, as well as on the agency's reputation.

The Need for Staff Training

Issues relating to ethics rarely are covered in orientation sessions or continuing education activities within agencies. Perhaps this is because these issues can be so personal and there are no right or wrong answers in many of the case examples. Yet, the intense nature of the job and the problemsolving required in the daily work of a substance abuse treatment professional require that further training about ethics be provided. This section can be a starting point for ongoing discussions among those treating persons with HIV in substance abuse treatment programs.

Basic Ethical Principles

The study of ethics has produced an abundance of writings, and many standards and principles have been brought forth. However, there are five general principles that provide a firm basis from which to explore the ethical concerns that arise daily in the substance abuse treatment and HIV/AIDS fields (Kitchener, 1985). These are reviewed below.

Justice

The principle of justice assumes impartiality and equality. It means that a clinician will treat all clients equally and give everyone their due portion of services. This principle applies to the individual client as well as on the larger societal level. Yet, given human nature, how possible is it really to treat everyone equally? Can it be honestly said that a clinician does not have "favorite" clients? Are there clients with whom a clinician instinctively wants to limit contact? Are there agency policies or informal agency practices that limit access to a program? Counselors may find that their comfort level is being challenged as increasing numbers of substance abusers with HIV/AIDS comprise their caseloads. Although they may have felt entirely comfortable working with someone who has a substance abuse disorder, they may not understand, or feel awkward working with, someone with HIV/AIDS.

While it is normal to have bias, it is important to know when and how it affects one's ability to practice within the principle of justice, so that no client is discriminated against or denied access to treatment that other clients have. This requires an understanding of countertransference--one's conscious and unconscious reactions to what the client may present in treatment. It also requires knowing when to ask for consultation with a supervisor, so that personal issues do not stand in the way of working with clients.

Although it may be difficult for a provider to treat everyone exactly the same, there are safeguards that agencies and providers can institute to ensure an equitable level of service. Standards can call for every new client to receive an intake interview within 24 hours, or the agency may work toward clarifying its criteria for services so that they are weighed more heavily on objective information rather than on the personal impressions of a substance abuse treatment worker. These sorts of policies can help ensure a general level of fairness, regardless of a worker's personal feelings.

Autonomy

The principle of autonomy assumes that individuals have the right to decide how to live their own lives, as long as their actions do not interfere with the welfare of others. This principle respects the unconditional worth of the individual and promotes the concepts of self-governance, self-determination, and self-rule. In working with HIV-infected substance abusers, the substance abuse treatment counselor can play a key role in determining if the client is competent to make his own decisions and establishing whether or not the client has the information needed to make a personal choice.

The issue of competence can be one of the most difficult ethical issues when working with this population. Persons with HIV/AIDS can be affected by numerous neuropsychiatric, metabolic, nutritional, and psychological concerns that can affect their judgment. Substance abusers also can experience poor judgment due either to active substance use or to the results of long-term use. In cases of incompetence, it is not fair to the client to allow for full autonomy in decision-making as the client could unwittingly harm himself. Yet it is not always clear whether the person is truly incompetent, and the process of proving incompetence can be burdensome and time consuming.

Competency issues are rarely clear cut. There are several factors that can temporarily make a client seem incompetent. A client may seem unable to make independent decisions one day, and then the next day be quite lucid. In reviewing a client's ability to maintain autonomy, consider not only the initial impression, but the duration and severity of the behavior, as well as reports by other persons in the client's life. Consultation with other medical or psychiatric professionals, reports by the client's support system, and a strong baseline assessment can help clarify the presence of mental state changes.

If it appears that a client may be experiencing a loss of mental functioning that is unrelated to a medication-based problem, the question of the client's competency must be addressed. Competency can be complete or partial in nature. The client may demonstrate full competency in some areas of her life and only partial competency in others. For instance, she may be quite capable of caring for herself physically but may no longer be able to make sound financial decisions. In this particular case, she may have to sign a power of attorney to allow someone else to deal with her financial affairs. (However, the client must be of sound mind before she can legally sign such an authorization; if the client is not of sound mind, provider staff should petition the court for appointment of a guardian to make such a decision.)

Before the client became incompetent, she may have signed other legal instruments, like a living will or health care proxy, and these may come into effect if the client appears to be incapable of attending to her own physical or medical care. Finally, if the client appears seriously incompetent, provider staff should petition the court to appoint a guardian.

The other issue involved in autonomous decisionmaking is whether the individual has the necessary information to make a sound decision. This is where bias and personal values on the part of the substance abuse treatment professional can cloud the issue. For example, a clinician strongly believes in combination therapy for persons with HIV and takes on a Native American client whose doctor is suggesting more aggressive treatment. The client wants to know about alternative therapies. Can the clinician set aside personal beliefs and provide an objective array of information without biasing the client's decision?

In many cases, it may be extremely difficult not to "push" the client toward a decision by emphasizing certain information. If nothing else, the biases should be acknowledged to the client. A client will then be able to listen to what the worker is saying, knowing that

there is a bias, and be able to respect the worker for acknowledging bias up front. In addition, the client may be more open to asking about the combination therapies at another stage in treatment because he was not "pushed" early on.

Beneficence

Beneficence assumes a responsibility to improve and enhance the welfare of others, or more simply put, to "do good" for others. But what does "doing good" really mean? What may be doing good in the eyes of the substance abuse treatment counselor may be seen as doing harm in the eyes of the client. The counselor needs to consider whether it is the client's agenda or his own agenda. The counselor's or agency's culture also may conflict with the client's. The role of the family, medical practices, and lifestyle issues all affect treatment, and these can differ greatly, depending on the various social norms of all those involved.

The issue of paternalism also must be considered. For example, a clinician might feel justified in telling a physician that the client is not a candidate for the complex regimen of combination therapy. The reasons for doing this may be justified to the clinician because the client is still using drugs and there is concern about the client's ability to take the medications. However, is the clinician's assumption that the client cannot comply based on fact or on personal perceptions and attitudes about drug abusers? In fact, some drug abusers live incredibly organized lives in order to maintain their addiction. Has the clinician discussed the regimen with the client, and has the client had the opportunity to advocate for herself? The clinician must take the client's point of view and cultural context into account before determining what "doing good" truly means.

Nonmaleficence

Similar to beneficence, nonmaleficence means "to do no harm." This principle often has been highlighted when discussing client exploitation, such as sexual contact or financial exploitation. Both of these examples are active means of doing harm to a client. However, doing harm also can be more subtle, especially given the complex population of HIV-infected substance abusers. An example of conflicting interpretations of this principle is in the debate over abstinence versus risk reduction approaches to drug treatment. Advocates of abstinence may claim that a risk reduction approach harms a client by enabling his addiction, keeping the client from truly "hitting bottom" and seeking help. Risk reduction advocates argue that the abstinence-based model harms the client because it does not allow for compassion or for meeting the basic needs of individuals who are in the throes of addiction. Advocates for risk reduction may claim that the abstinence-based model actually prohibits recovery because it does not take into account that recovery is a process, rather than a rigid philosophy. This is one ethical dilemma that truly reflects the passionate nature of personal values and beliefs.

Another example, on a micro level, is termination or transfer of clients. In both the HIV/AIDS and substance abuse treatment fields, there is a high degree of staff burnout. As an individual clinician becomes increasingly stretched, her ability to be flexible with

clients and to treat them as individuals diminishes. In some situations, a client who breaks a rule or shows up late may suffer the wrath of a clinician only because he is the third client to show up late that day, and this is the last time the clinician is going to deal with a lack of respect. Thus, the client may be terminated or transferred to another clinician. This may be a fairly common experience, but what does it mean to the client? Will it harm the development of future relationships? What if the client knows of other clients who were late that day but who were not transferred or terminated? What impression does that give the client about her own self-worth?

Clinicians must be sure that they are not acting like parents to clients and making the clients feel like bad children. If rules regarding transfers and terminations are not clear from the start and followed through consistently, then the clinician is violating the principle of nonmaleficence.

Fidelity

The principle of fidelity requires telling the truth and keeping promises. Fidelity is a fairly simple concept that can be violated easily. When a substance abuse treatment counselor takes on a client, there is an implicit contract with the client. The contract assumes that the counselor will work to resolve the client's concerns and that information will be shared in a truthful manner between the counselor and the client. By having the client sign consent forms, the counselor is promising that the information provided will remain confidential to anyone who is not listed on the form. The client agrees to follow the agency's rules. (Of course, confidentiality must be extended to the client whether or not he obeys program rules.) How frequently is the first session taken up with the more interesting issues, and the paperwork given to the client quickly at the end?

If a clinician is going to keep promises, he must be clear up front about when the promises may have to be broken. If the client is suicidal or homicidal, for example, confidentiality may be breached. If the client speaks of child abuse, the contract will be breached. If the client breaks certain agency rules, the relationship between the clinician and the client may be terminated. It is important that the clinician is extremely clear about the limitations to fidelity so there are no surprises later on. (See the "Confidentiality" section later in this chapter and Chapter 9 for specific details about the legal issues involved.)

Another issue of fidelity is the counselor's focus on the primary client. If the counselor is involved with a complicated family system, it can be difficult to remember who the client is, especially at times of conflict. In working with clients who have questionable competency, it can be convenient to let someone else speak for the client. But it is the counselor's responsibility to ensure that until the competency issue is resolved, she will have to represent the primary client and act according to the client's wishes.

Ethical Issues in Working With HIV-Infected Substance Abusers

There are several specific ethical issues that predominate in the substance abuse and

HIV/AIDS treatment fields that warrant more focused attention. These issues are discussed below in a social and ethical context; further information on the legal aspects of these issues is provided in Chapter 9.

Duty To Treat

The duty to treat, from an ethical perspective, is especially relevant when working with disenfranchised populations. A clinician involved with homeless, chronic alcohol-dependent individuals may find it difficult to access adequate medical care for a client with HIV. Or it may not be easy to find a dentist willing to work with an HIV-infected client. Substance abuse treatment professionals may have to take on an advocacy role within their community to educate and campaign for care.

At the same time, it is important that the counselor and the counselor's agency appear accessible to all and that there are no restrictions that could impede the care of one client just because the client is different in some way.

The impact of welfare reform may augment concern about access issues. This is compounded by the increasing focus on managed care and the decreasing availability of health insurance for the poor. Adding restrictions to a population that is already disenfranchised will require more creativity, patience, and determination on the part of the clinician who is trying to advocate for a client.

In addition, it is important for clinicians to remember that when taking the ethically or morally correct action in a duty-to-treat situation they do not inadvertently create situations where the clinician and agency are legally culpable. Take the example of a counselor who has a substance abuse client who is a minor and engages in prostitution in exchange for drugs. This client is at a high risk of contracting HIV. The counselor feels ethically obligated to treat the client and intervenes to help the client receive clinical treatment or receive information about HIV in a medical setting. Later the client's parents say that they did not approve the medical treatment for their child, and a legal situation is created.

Duty To Warn

In working with HIV-infected substance abusers, there are unique concerns that are raised regarding the duty to warn. Besides the more obvious issues relating to reporting abuse and suicidal or homicidal threats, providers are concerned about clients who are transmitting HIV by not taking necessary precautions. For example, there have been several high profile news reports about individuals with HIV who knowingly infected multiple partners through sexual contact (Richardson, 1998). What does a clinician do if she knows that a client is aware of his HIV-positive status but is still not taking precautions?

Again, counselors must be aware of creating legal culpabilities when taking the ethically or morally correct action in a duty-to-warn situation. For example, if a client has HIV but

has not informed his partner about his HIV status, the counselor could be held liable in a civil law suit for knowing and not telling the client's partner. Counselors should consult with their supervisors about agency policy regarding duty-to-warn situations and may report the client to the public health department. Each situation should be examined on a case-by-case basis.

For some counselors, the knowing transmission of HIV is as serious as hearing their client threaten to kill someone. There are some differences, however, between knowingly transmitting HIV and murder. For one, the campaign to stop the transmission of HIV has encouraged people to protect themselves. Therefore, every individual is responsible for safer sex practices, so it is not entirely the responsibility of the person with HIV. Additionally, how can a counselor realistically prevent a client from sharing contaminated syringes or having sex? Finally, there is a greater chance that by using education and counseling, a clinician may be more successful in convincing a client to use protective measures than if the clinician immediately threatened punitive action.

This situation also highlights the conflicts between principles such as beneficence, fidelity, and nonmaleficence. Is the provider "doing good" by reporting a client and trying to help the greater society? Or is the provider doing harm by not working with the client to stop the behavior on a long-term basis? To what extent is the provider breaking the contract with the client by disclosing the client's actions? The ethical nature of these kinds of dilemmas does not lend itself to an easy decision but requires a case-by-case analysis while looking at the long-term and immediate consequences of action (Reamer, 1991). See Chapter 9 for more information about the legal implications of duty-to-warn issues.

End-of-Life Issues

Treatments for HIV are dramatically lowering the death rate from AIDS, but people are still dying from this disease. When an individual's HIV status is compounded by chronic drug use, her survival is less likely. Thus, a clinician may be faced with dying clients and the ethical dilemmas that relate to dying. Persons with HIV generally have been vocal about their right to self-determination. They have campaigned for access to drugs that are still in the trial stage, they have fought for organizations that advocate for dying individuals, such as the Hemlock Society and Compassion in Dying, and they have been highly effective in organizing a compassionate continuum of care services within certain communities, especially the gay and lesbian communities. Given this activist culture, a client with HIV may decide at a certain point to stop medical interventions and will not expect to be dissuaded in this decision.

In some cases, a client may decide that he wishes to end his life because treatment is not working. Clearly, this has implications for the clinician, who should make it clear that he cannot hold a client's suicide threat confidential. The worker should also tell the client again, at the time the threat is made, that he plans to report it. It is important that the clinician discuss the limitations of his role clearly with the client and that this discussion take place before the client reveals, for example, that she is going to take an overdose of

medication. The clinician should explain the professional and agency limitations, and what he would have to do if the client provided certain information. This provides the client with the information needed to make a later decision not to tell the clinician about any such intentions (or, if the client wants intervention, she may decide to tell the clinician, knowing where such information would lead). It is imperative that providers recognize the laws in their own jurisdictions regarding these issues.

For providers who are concerned about liability, it is helpful to note that if a case were to go to court, the provider would be judged on the community standard for that profession. Thus, if the clinician were following the code of ethics for the profession and it was well documented, or if the clinician was adhering to the accepted standards of the institution in which he worked, the chances of being found liable in a lawsuit are greatly reduced. Although there is much concern about liability in the profession of social services, it is extremely rare for a judgment to be made against a clinician who was following appropriate procedures and standards.

Dual Relationships

Dual relationships pose another dilemma that clinicians may find themselves in. Dual relationships, where a provider may have had contact with a client in a social context as well as in a professional role, bring up the ethical issue of boundaries. The line between social and professional roles can become blurred, especially in rural areas or in certain cultural communities. In the treatment provider network, a clinician may be seeing someone with whom she used to socialize or shoot up, or a gay male counselor may be case managing a peer from his community.

Dual relationships should be avoided if possible. A clinician who knows a client via a past social or sexual encounter should not assume a professional role with that client. Some clients may avoid accessing services because they are afraid of seeing someone they know, and the ethical issues regarding disclosure and trust are many. If there is no other provider available to the client, it is imperative that the clinician clarify what the professional role means, and how the information shared will remain confidential. It may also be necessary throughout the treatment process to frequently check the client's comfort level and to continually emphasize the role and boundaries of the clinician.

Scarce Resources

Given the limited resources available, treatment providers may find it difficult to treat all the clients who seek treatment. Providers will need to plan for the complex decisions that need to be made in such cases. They should consider the following questions:

How can providers, and society in general, ensure that resources are distributed fairly? How can such allocations be free of bias and assumptions about certain

individuals, cultures, and populations?

The provider can work to make certain that the method of allocation is objective and applied consistently. This means using objective criteria for access to services or treatment and perhaps instituting a review process to ensure that decisions are not made only on the basis of one provider's recommendation. In some facilities or agencies, for example, there is a team that determines who qualifies for services once certain objective eligibility criteria have been met.

Resources available to many substance abuse treatment providers, particularly for clients with HIV/AIDS, are limited. As interest in HIV has "peaked," organizations serving this population have seen revenues drop. As a result, an agency needing to limit services to a specific number of people may turn down an individual who has failed in treatment a number of times. The justification may be that the resources could be better spent on someone who has a greater likelihood of recovery.

Issues such as these also are affecting the allocation of combination therapies. The provider may block a client's access to the expensive treatments if the client is not up to managing the medication regimen. The case manager or treatment specialist who sees the client on a consistent basis can support or deny the validity of such a decision.

Confidentiality

The issue of confidentiality is the "connecting issue" among the general principles outlined above (NASW, 1997). Ensuring confidentiality is perhaps the strongest element in the foundation of a therapeutic relationship. Clients must feel that what they say to a clinician is protected information. Unfortunately, the nature of managed care requires more extensive justification for treatment, and the number of individuals that need information about a person's treatment is increasing. Additionally, the influx of computerized data can further jeopardize the concept of protected information.

It is the ethical responsibility of the provider to be honest with the client about what data need to be reported to funding sources such as insurance companies, and what information needs to be shared with other agencies or individuals. It is the legal responsibility of the provider to obtain consent for any information shared outside of the client-provider relationship (see Chapter 9). A provider must ensure that clients understand the agreement they are entering into by accepting treatment from the agency or provider. Clients should have all the information they need to make decisions about the services being provided, including to what specific amount and types of disclosure they are willing to consent.

This does not mean that the provider has no control over what is disclosed to others about the client. It is imperative that the provider use discretion in conversations with individuals outside of the therapeutic relationship and only report what is relevant to the situation. The provider also should use discretion in documentation of work with the client. Some providers document everything in detail in case they are sued. The provider

should only document what is essential. For example, if a client comes into treatment for substance abuse, the provider should document the client's substance abuse history, motivation for entering treatment, any medical or emotional issues that relate to the treatment, and the plan for service. But there is a significant difference between an entry that states, "Client is upset regarding recent divorce," and an entry that reads, "Client claims his ongoing promiscuity has caused his wife to leave him." The latter may be of interest, and perhaps even relevant to treatment, but it should not be documented until it is necessary treatment information.

A Step-by-Step Model for Making Ethical Decisions

All programs should have a consistent process for dealing with ethical concerns. Although ethical issues are usually complex enough to require a case-by-case evaluation, agency practices should provide for a routine process for approaching an ethical issue. For example, an agency might have, as a policy and procedure, a practice where the employee consults with a supervisor or an ethics consultation team within the agency, within a specified timeframe, and guidelines are provided for how to document such discussions. There could also be agency protocols for situations that have arisen in the past, such as a client's admission that she is suicidal or homicidal, clients who come to the facility intoxicated and insist on driving home, or clients who admit to illegal activity. Given the ambiguous nature of ethical dilemmas, it is helpful to clarify the process for resolving dilemmas, even if the resolution may differ from case to case.

NASW's *Ethical Issues, HIV/AIDS, and Social Work Practice* training manual (NASW, 1997) outlines a process for working through ethical issues. By practicing the following steps, suggested by the NASW, the clinician can move to a more rational level of decisionmaking.

Identify the clinical issues. When an ethical issue arises, the provider should review the larger picture in her work with the client or system. Identifying the clinical issues is the first step. What are the clinical needs of the client? How does the ethical dilemma relate to what the client presented with initially? It is important to assess the clinical issues so that pertinent information is not missed. For example, if a client with advanced AIDS is asking for help in ending his life, the provider would review the client's previous mental health history and current emotional issues, look for any significant changes in the client's support system, and determine if the client is experiencing social or psychological issues that might influence his decision. Until this is done, it is impossible for the clinician to address the ethical issue regarding end of life.

Identify the legal issues. There can be significant legal issues to consider. Has the clinician reviewed the State and local laws regarding the issue? If necessary, has the clinician checked with an attorney for consultation or informed his supervisor of possible liability questions?

Identify the system issues. What are the policies and procedures of the clinician's agency regarding the ethical question? In some agencies, the answers may be hard to find, but they can shed light on any restrictions the clinician may face or make

the choices clear. For example, if it is against policy to accept a gift from a client, the clinician can avoid a personal rejection by referring to the policy. Agency policy also can help a clinician in a legal challenge. For example, if the clinician followed agency policy, it is less likely that the clinician can be challenged legally for actions pertaining to that policy (although the agency can still be challenged).

Identify the cultural issues. Cultural issues often are glossed over in the midst of a dilemma or crisis. Yet cultural issues are significant for understanding the client's motivation and whether or not the client will act according to the proposed treatment plan. For example, a gay, African American client may have difficulty dealing with his homosexuality and as a result may be having anonymous unprotected sex impulsively. In the African American culture it can be especially difficult for men to acknowledge their homosexuality. If the client is HIV positive, there is an ethical need to educate him about protecting others. If the clinician does not acknowledge the client's discomfort on a cultural level, the education process will be limited and the clinician will miss the "larger picture."

Identify the ethical issues. What is the clinician's reaction to the situation? Ethical issues often are revealed when there is a "gut instinct" that something is not right. Confusion, anxiety, or uncertainty about what to do next with the client are indicators that an ethical issue is at stake. If basic principles seem to be compromised, the clinician should stop and evaluate further. A significant step is for the clinician to examine her own feelings about the situation. The clinician needs to identify any countertransference issues regarding the situation to ensure that the issue can be viewed objectively.

Review what principles are at stake. What is the true dilemma? Is there a dilemma at all? So much can be occurring with a client that it is difficult to see the real issue, or whether the issue is significant. Is harm being done either by the client or to the client? Can the client make her own decisions, and is she not being allowed to do so? Is the client being treated fairly regardless of race, culture, or lifestyle? Is there a threat to the client's confidentiality? These are the questions relating to basic ethical principles.

What are the possible options? By this point, the clinician's next step may be clear already. Or, there may be choices of possible options. It is useful to simply list all of the possible options and then examine them.

Review the pros and cons of each option. List the pros and cons of each possible option, noting the impact of the options on the welfare of the client, the clinician, the agency, and others involved in the situation, such as the client's support system.

Act. At this point, the clinician should be ready to make a decision. Sometimes the decision may not be one that everyone is comfortable with, but it may be the least objectionable plan. The client should understand the rationale for the clinician's decision, and there should be evidence of the clinician's thought process in the documentation of consultations, discussions with the client, and supervisory meetings.

Follow up and evaluate. An ethical decision should be evaluated and the impact to the client monitored. For example, if the clinician decided to breach confidentiality for the protection of the client, how has this affected the clinical

work with the client? These issues should be considered once an initial crisis has passed.

Additional Resources for Ethical Problemsolving

This section identifies several resources that can provide professional guidance on ethical issues.

Consultation

Consultation can be formal or informal. A supervisor is an obvious choice but may not always be available in some resource-strapped agencies or facilities. In lieu of formal supervision, there can be consultation with peers, lead workers, or other providers within the community who understand what the clinician does. For cultural questions, it is vital to use the community that represents that culture; however, the clinician should be cautious about consulting individuals who claim to represent the community but in actuality do not. The clinician also needs to ensure confidentiality with any consultation. If there is a chance that the information cannot be shared without divulging confidentiality, the provider may have to contact resources from another city, county, or State to ensure that the client's confidentiality is not threatened. Without the client's consent, however, the provider should never share identifying information.

Professional Standards or Codes of Ethics

Professional standards, and the documents that reflect them, are another resource. Social work, medicine, nursing, and psychology are examples of professions that have professional standards and codes of ethics. These documents do not provide answers to every ethical dilemma, but they do provide parameters for what is allowed or disallowed by the profession. They may also provide substantive questions to guide a provider toward making a decision. To find such documents, contact the association office for the particular professional group.

Legal Consultation

For many providers, obtaining legal advice may seem unrealistic given limited resources, but there are low-cost strategies for obtaining advice in some situations. Most bar associations have a pro bono legal component that may provide consultation at no charge or at a reduced rate. Legal service agencies that operate as a social service to the community may have expertise regarding certain ethical dilemmas. Another often untapped resource is the board of the organization that employs the clinician. The board is legally responsible for any impact to the agency, so it would have a vested interest in assisting with a decision that could have legal repercussions. Many boards have attorneys as members.

It is worthwhile to examine the agency board, discover the specialty areas of the

individuals who make up the board, and talk with the agency administration about building a relationship with those board members in advance of a legal issue. In addition, there is a Single State Authority charged with funding and regulating the field of substance abuse treatment. Such an entity may have an attorney available who can assist with legal issues relating to treatment.

Legal Issues

A number of legal issues can affect HIV-infected clients and the operations of substance abuse treatment programs. With multiple sets of rules governing HIV/ AIDS as well as substance abuse treatment, compliance can be tricky. This chapter examines legal issues (many of them with ethical implications) in two main areas:

1. Access to services and programs, as well as employment opportunities for recovering substance abusers and persons living with HIV/AIDS
2. Confidentiality, or the protection of clients' right to privacy

Both of these areas are covered by Federal and State laws, which are often attempts to address the ethical concerns involved.

Access to Treatment--Issues of Discrimination

Substance abuse treatment providers may encounter discrimination against their clients as they try to connect them with services. Although people have come a long way from the early days of the AIDS pandemic (when people were afraid to have any contact with someone infected with HIV), there are still many instances in which people living with HIV/AIDS are shunned, excluded from services, or offered services under discriminatory conditions. As recently as 1998, the United States Supreme Court considered a case against a dentist who refused to treat a patient in his office. He stated he would only treat her in a hospital (although her situation did not warrant an admission) and that she would have to incur those costs herself.

People in substance abuse treatment also may encounter outright rejection or discrimination because of their history of drug or alcohol use. A hospital might be unwilling to admit a client who relapses periodically. Or a long-term care facility may be reluctant to accommodate a client who is maintained on methadone.

Individuals living with HIV/AIDS and persons in substance abuse treatment may also encounter discrimination in employment. A school may refuse to hire a teacher who is HIV positive, or a business may fire a secretary when it discovers she once was treated for alcoholism.

This section outlines the protections Federal law currently affords people with substance abuse problems and people living with HIV/AIDS, as well as the limitations of those protections. State laws that outlaw discrimination against individuals with disabilities are also mentioned.

Federal Statutes Protecting People With Disabilities

Two Federal statutes protect people with disabilities: the Federal Rehabilitation Act (29 United States Code [U.S.C.] §791 et seq. [1973]) and the Americans With Disabilities

Act (ADA) (42 U.S.C. 12101 et seq. [1992]). (In this section these are referred to collectively as "the acts.") Together, these laws prohibit discrimination based on disability by private and public entities that provide most of the benefits, programs, and services a substance abuser or person living with HIV/AIDS is likely to need or seek. They also outlaw discrimination by a wide range of employers. For a general discussion about these Federal statutes, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT, 1998c).

Protections for substance abusers and persons living with HIV/AIDS

The issue for treatment providers is whether substance abusers and people living with HIV/AIDS are included in the definition of "individual with a disability." The answer is yes in many, but not all, instances.

Alcohol abusers

In general, these acts protect alcohol abusers who are seeking benefits or services from an organization or agency covered by one of the statutes (29 U.S.C. §706(8)(C)(iii) and 42 U.S.C. §12110(c)), if they are "qualified" and do not pose a direct threat to the health or safety of others (28 Code of Federal Regulations [CFR] §36.208(a)). This means that an organization or program cannot refuse to serve an individual unless

- The individual's alcohol use is so severe, or has resulted in other debilitating conditions, that he no longer "meets the essential eligibility requirements for the receipt of services or the participation in programs_with or without reasonable modifications to rules, policies, or practices ._" (42 U.S.C. §12131(2)).
- The individual poses "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services" (36 CFR §36.208(b); Supplemental Information 28 CFR Part 35, Section-by-Section Analysis, §35.104).

For example, a hospital might take the position that an alcohol-dependent client with dementia was not "qualified" to participate in occupational therapy because he could not follow directions. Or an alcohol abuser whose drinking results in assaultive episodes that endanger elderly residents in a long-term care facility might pose the kind of "direct threat" to the health or safety of others that would permit his exclusion.

The Rehabilitation Act also permits programs and activities providing services of an educational nature to discipline students who use or possess alcohol (29 U.S.C. §706(8)(C)(iv)). Abusers of illegal drugs

The acts divide abusers of illegal drugs into two groups: former abusers and current abusers.

Former abusers. Individuals who no longer are engaged in illegal use of drugs and have completed or are participating in a drug rehabilitation program are protected from discrimination to the same extent as alcohol abusers (29 U.S.C. §706(8)(C)(ii); 42 U.S.C. §12210(b)). In other words, they are protected so long as they are "qualified" for the program, activity, or service and do not pose a "direct threat" to the health or safety of others. Service providers may administer drug tests to ensure that an individual who once used illegal drugs no longer does so (28 CFR §36.209(c); 28 CFR §35.131(c)).

Current abusers. Individuals currently engaging in illegal use of drugs are offered full protection only in connection with health and drug rehabilitation services (28 CFR §36.209(b) and 28 CFR §35.131(b)). (However, drug treatment programs may deny participation to individuals who continue to use illegal drugs while they are in the program (28 CFR §36.209(b)(2)).) The laws explicitly withdraw protection with regard to other services, programs, or activities (29 U.S.C. §706(8)(C)(i) and 42 U.S.C. §2210(a)). Current illegal use of drugs is defined as "illegal use of drugs that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem" (28 CFR §35.104 and 28 CFR §35.104).

For example, a hospital that specializes in treating burn victims could not refuse to treat a burn victim because he uses illegal drugs, nor could it impose a surcharge on him because of his addiction. However, the hospital is not required to provide services that it does not ordinarily provide; for example, drug abuse treatment (Appendix B to 28 CFR Part 36, Section-by-Section Analysis, §36.302). On the other hand, a homeless shelter could refuse to admit an abuser of illegal drugs, unless the individual has stopped and is participating in or has completed drug treatment.

The Rehabilitation Act also permits programs and activities providing educational services to discipline students who use or possess illegal drugs (29 U.S.C. §706(8)(C)(iv)). Individuals living with HIV/AIDS

Although alcohol and drug abuse are mentioned in both of the acts, HIV/AIDS is not. However, on June 25, 1998, the United States Supreme Court held that asymptomatic HIV infection is a "disability" under the ADA (Bragdon v. Abbott, 524 U.S. 624 [1998]. See also 28 CFR §35.104 and §36.104; 28 CFR Part 35, Section-by-Section Analysis, §35.104 and Appendix B to 28 CFR Part 36, Section-by-Section Analysis, §36.104). In this case, a woman with asymptomatic HIV disease sued a dentist who denied her equal service.

The *Bragdon* v. *Abbott* decision means that individuals living with HIV/AIDS are protected from discrimination under both of the acts, so long as they are "qualified" for the service, program, or benefit and do not pose a "direct threat" to the health or safety of others. (See also 28 CFR §36.208; Supplemental Information 28 CFR Part 35, Section-by-Section Analysis, §35.104.) An individual who is too ill to participate in a program,

even with reasonable modifications, might not be "qualified."

The "direct threat" question has received the most public attention. Can a "public accommodation," a restaurant, hospital, school, or funeral home, refuse to provide services to someone living with HIV/AIDS because the person poses a "direct threat" to the health and safety of others? Because HIV is not transmitted by casual contact, and most programs and services provided by "public accommodations" involve only casual contact, the answer in most cases should be "no." Even when contact with bodily fluids is likely to occur, public health authorities advise health care professionals to treat HIV-positive clients in the normal setting and to use universal precautions with all clients. Moreover, in those cases where a public accommodation could argue that an HIV-positive individual poses a direct threat, it would also have to show that the threat could not be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.

Protections in the area of employment

Alcohol-dependent and alcohol-abusing persons. The acts provide limited protection against employment discrimination to individuals who abuse alcohol but who can perform the requisite job duties and do not pose a direct threat to the health, safety, or property of others in the workplace (29 U.S.C. §706(8)(C)(v); 42 U.S.C. §12113(b); 42 U.S.C. §12111(3)). For example, the acts would protect an alcoholic secretary who binges on weekends but reports to work sober and performs her job safely and efficiently. However, a truck driver who comes to work inebriated and unable to do his job safely would not be protected. The employee whose promptness or attendance is erratic would not be protected either, unless the employer tolerated nonalcoholic-employee lateness and absences from work.

The ADA also permits an employer to

- Prohibit all use of alcohol in the workplace
- Require all employees to be free from the influence of alcohol at the workplace
- Require employees who abuse alcohol to maintain the same qualifications for employment, job performance, and behavior that the employer requires other employees to meet, even if any unsatisfactory performance is related to the employee's alcohol abuse (42 U.S.C. §12114(c))

Abusers of illegal drugs. Those who use or have used illegal drugs stand on a different footing. Former abusers who have completed or are participating in a drug rehabilitation program are offered some protection. The acts protect employees and prospective employees who

- Have successfully completed a supervised drug rehabilitation program or otherwise been rehabilitated and are no longer engaging in the illegal use of drugs
- Are participating in a supervised rehabilitation program and are no longer engaging in illegal drug use

Are erroneously regarded as engaging in illegal drug use (29 U.S.C. 706(8)(C)(ii); 42 U.S.C. §12210(c))

Employers may administer drug testing to ensure that someone who has a history of illegal drug use is no longer using (29 U.S.C. §706(8)(C)(ii); 42 U.S.C. §12210(b); 28 CFR §36.209(c); 28 CFR §35.131(c)).

The ADA also permits an employer to

Prohibit all use of illegal drugs in the workplace Require all employees to be free from the influence of illegal drugs at the workplace

Require an employee who engages in the illegal use of drugs to maintain the same qualifications for employment, job performance, and behavior that the employer requires other employees to meet, even if any unsatisfactory performance is related to the employee's drug abuse (42 U.S.C. §12114(c))

Another Federal law, the Drug-Free Workplace Act (41 U.S.C. §701), may also affect clients in recovery. The Act requires employers who receive Federal funding through a grant (including block grant or entitlement grant programs) or who hold Federal contracts to certify they will provide a substance-free workplace. The certification means that affected employers must

Notify employees that "the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specify the actions that will be taken against employees [who violate the] prohibition"

Establish an ongoing substance-free awareness program to inform employees of the dangers of substance abuse in the workplace, the availability of any substance abuse counseling or employee assistance program, and the penalties that may be imposed for violations of the employer's policy
Take appropriate action against an employee convicted of a substance abuse offense when the offense occurred in the workplace Notify the Federal funding agency in writing when such a conviction occurs

Current abusers have no protection against discrimination in employment, even if they are "qualified" and do not pose a "direct threat" to others in the workplace (29 U.S.C. §706(8)(C)(i); 42 U.S.C. §12210(a)).

People living with HIV/AIDS. The Supreme Court's decision in *Abbott*, that "disability" includes symptomatic and asymptomatic HIV disease, should apply in the area of employment. See also 28 CFR §35.104; Appendix to 29 CFR Part 1630C Interpretive Guidance on Title I of the Americans with Disabilities Act, §1630.2(j)

("impairments_such as HIV infection, are inherently substantially limiting"). This means that an individual living with HIV/AIDS is protected from employment discrimination as long as he is "qualified," that is, he can, with or without reasonable accommodation, perform the essential functions of the job and does not pose a "direct threat" to others in the workplace.

Reasonable accommodation can include a modified work schedule or reassignment to a vacant position. The "direct threat" issue has been most controversial and was left undecided by the court in *Abbott*. Can an employer running a restaurant, school, beauty salon, or construction company refuse to hire a person living with HIV/AIDS on the basis that the person poses a "direct threat" to coworkers, customers, or others in the workplace? Not if it bases its judgment solely on the individual's HIV/AIDS status. Because most employment involves only casual contact, an HIV-infected individual does not pose a risk to other employees, diners, students, or customers. Even in cases where an employer could argue that an HIV-infected individual poses a direct threat, it would also have to show that the threat could not be eliminated through a reasonable accommodation.

Therefore, in most cases, an employer could not refuse to hire and retain a person living with HIV/AIDS. However, if a person living with HIV/AIDS suffers from a physical condition such as blurred vision or dizziness that might pose a risk if he operates dangerous equipment, the employer might be justified in refusing to hire the person or curtailing the employee's activities after making the individualized assessment required by regulation (29 CFR §1630.2(r)).

The Civil Rights Division of the U.S. Department of Justice has issued a useful "Q & A" about the ADA's protections for persons living with HIV/AIDS. It poses and answers questions about employment discrimination and discrimination by "public accommodations" and State and local governments and gives many helpful examples. It also contains a listing of places to find help. It can be found on the Internet at http://www.usdoj.gov/crt/ada/pubs/hivqanda.txt.

State Laws

Most States have also enacted laws to protect people with disabilities (or "handicaps"). Some State laws protect alcohol abusers, drug abusers, and persons living with HIV/AIDS. Each State's laws are different, and a treatment provider seeking help under State law should make contact with the State or local agency charged with enforcing State civil rights laws. Such agencies often have the words "civil rights," "human rights," or "equal opportunity" in their titles.

Enforcement

Discrimination against substance abusers and individuals living with HIV/AIDS continues despite the existence of the acts. However, these laws offer those who believe

they have suffered discrimination a choice of remedies.

For discrimination by program or activity

Filing a complaint with the Federal agency that funds the program, activity, or service (42 U.S.C. §12133; 29 U.S.C. §794(a); 28 CFR Part 35, Subparts F and G). For example, if the program is educational, it may receive funding from the Department of Education; if it involves health care, it may be funded by the U.S. Department of Health and Human Services (DHHS). Once a complaint is filed, one or more of the following actions will be taken:

- The agency will investigate and attempt an informal resolution. If a resolution is reached, the agency drafts a compliance agreement enforceable by the U.S. Attorney General.
- If no resolution is achieved, the agency issues a "Letter of Findings." The Letter of Findings contains findings of fact, conclusions of law, a description of the suggested remedy, and a notice of the complainant's right to sue. A copy is sent to the U.S. Attorney General.
- The agency must then approach the offending program about negotiating. If the program refuses to negotiate or negotiations are fruitless, the agency refers the matter to the U.S. Attorney General with a recommendation for action.

Advantages: A complaint to the Federal funding agency may get the offending program's attention (and change its decision) because the funding agency has the power to deny future funding to those who violate the law. It is also inexpensive (no lawyer is necessary); however, if the complainant opts to be represented by an attorney, he may be awarded attorneys' fees if he prevails.

Disadvantage: Depending on the kind of complaint and which Federal agency has jurisdiction, this may not be the most expeditious route.

Filing a complaint with the State administrative agency charged with enforcement of the antidiscrimination laws (42 U.S.C. §12201(b)). Such agencies often have the words "civil rights," "human rights," or "equal opportunity" in their titles.

Advantage: This recourse is inexpensive.

Disadvantages: Some of these agencies have large backlogs that generally preclude speedy resolution of complaints. Depending on the State, remedies may be limited.

Filing a case in State or Federal court. One can file a court case requesting injunctive relief (temporary or permanent) and/or monetary damages. The court has the discretion to appoint a lawyer to represent the plaintiff (42 U.S.C. §§12188 and 2000a-3(a); 28 CFR §36.501).

Advantages: The complainant can ask for injunctive relief (a court order requiring the

program to change its policy) and/or monetary damages. It may give the complainant a better sense of control over the process. A lawyer may produce results relatively quickly. A lawyer's approach to an offending program can have prompt and salutary effects. No one likes to be sued; it is costly, unpleasant, and often very public. It is often easier to reexamine one's position and settle the case quickly out of court.

Disadvantages: Unless one can find a not-for-profit organization that is interested in the case, a lawyer willing to represent the aggrieved party pro bono, or a lawyer willing to take the case on contingency or for the attorneys' fees the court can award the side that prevails, this may be an expensive alternative. It also may take a long time.

The advantages and disadvantages of filing a case in State court depend on State law, State procedural rules, and the speed with which cases are resolved.

Requesting enforcement action by the U.S. Attorney General. The Attorney General can file a lawsuit asking for injunctive relief, monetary damages, and civil penalties (42 U.S.C. §12188 and 2000a-3(a); 28 CFR §36.503).

For employment discrimination

Filing a complaint with the Federal Equal Employment Opportunity Commission (EEOC) (42 U.S.C. §12117) **or the State administrative agency charged with enforcement of antidiscrimination laws** (42 U.S.C. §12201(b)).

If the EEOC finds reasonable cause to believe that the charge of discrimination is true, and it cannot get agreement from the party charged, it can bring a lawsuit against any private entity. If the offending entity is governmental, the EEOC must refer the case to the U.S. Attorney General, who may file a lawsuit. The complainant can intervene in any court case brought by either the EEOC or the U.S. Attorney General. The EEOC or the U.S. Attorney General can also seek immediate relief by filing a motion for a preliminary injunction in a Federal court.

The court can order injunctive relief, including reinstatement or hiring, back pay, and attorneys' fees (42 U.S.C. §2000e-5).

Advantage: A complaint to the EEOC, the U.S. Department of Justice, a State or local antidiscrimination agency, or State Attorney General is relatively inexpensive because it does not require a lawyer.

Disadvantage: Some of these agencies have large backlogs that generally preclude speedy resolution of complaints.

Filing a lawsuit in State or Federal court. After an aggrieved party has filed a complaint with the State administrative agency and/or the EEOC, he can file a lawsuit (42 U.S.C. §2000e-5(f)).

Advantages: It may give the complainant better control over the process. The complainant can ask for injunctive relief (a court order requiring the employer to change its policy) and/or monetary damages. It can get relatively fast results. A lawyer's approach to an offending employer can have salutary effects. No one likes to be sued--it is costly, unpleasant, and often very public. It is often easier to re-examine one's position and settle the case quickly out of court.

Disadvantages: Unless one can find a not-for-profit organization that is interested in the case, a lawyer willing to represent the aggrieved party pro bono, or a lawyer willing to take the case on contingency or for the attorneys' fees the court can award the side that prevails, this may be an expensive alternative. It may also take a long time.

The alternatives listed here must be pursued within certain time limits established by State and Federal laws. An individual who is considering filing a complaint with any one of the agencies mentioned above should consult an attorney at an early date to determine when a complaint must be filed.

Summary of Protections

Federal law provides broad protection against discrimination by programs, services, and employers for individuals in substance abuse treatment who are also living with HIV/AIDS. Many States also have laws prohibiting discrimination against "individuals with disabilities" or "handicaps," and some of these statutes also protect recovering substance abusers and individuals living with HIV/AIDS. To learn more about State law, the protections it offers, and the available remedies, providers can call the State or local "human rights," "civil rights," or "equal opportunity" agency. Advocacy groups for individuals with disabilities are also a good source of information. (An AIDS advocacy group would be particularly well informed.) Finally, local legal services offices, law school faculties, or bar associations may also have information available or may be able to provide an individual lawyer willing to make a presentation to staff.

Confidentiality of Information About Clients

Programs providing substance abuse treatment for clients living with HIV/AIDS frequently must communicate with individuals and organizations as they gather information, refer clients for services the program does not provide, and coordinate care with other service providers. On occasion, they are required to report information to the State. This section outlines the laws protecting client confidentiality and examines how staff can continue to provide appropriate treatment services, comply with State reporting laws, and protect client privacy.

Information about clients in substance abuse treatment who are living with HIV/AIDS is subject to two sets of laws:

> Federal statutes and regulations that guarantee the confidentiality of information about all persons applying for or receiving alcohol and drug abuse prevention,

screening, assessment, and treatment services (42 U.S.C. §290dd-2; 42 CFR, Part 2)

State laws governing the confidentiality of HIV/AIDS-related information. (State laws protecting HIV-related information vary in the protection they offer; some guard clients' privacy closely, others are more lenient. State laws also protect the confidentiality of other medical and mental health information. These laws, however, are likely to be less stringent than statutes dealing specifically with information about HIV/AIDS.)

The remainder of this chapter describes what these laws require and examines their impact on substance abuse treatment programs. The first section contains an overview of the Federal law protecting the right to privacy of any person who seeks or receives substance abuse treatment services. Because the Federal law applies throughout the country and preempts less restrictive State laws, this discussion focuses on how the Federal rules apply in a variety of situations, then addresses related State laws in those contexts. Next is an examination of the rules surrounding the use of consent forms to obtain a client's permission to release information, including ways to handle requests for disclosure when the client's file contains both substance abuse and HIV/AIDS information.

The third section reviews situations that commonly arise when a client in substance abuse treatment is living with HIV/AIDS, including how communications among agencies providing services to the client can be managed. The fourth section discusses exceptions in the Federal confidentiality rules that, in limited circumstances, permit disclosure of information about clients (e.g., reporting child abuse or neglect). The chapter ends with a few additional points concerning the requirement that clients receive a notice about the confidentiality regulations, clients' right to review their own records, and security of records.

Federal and State Laws Protect the Client's Right to Privacy

A Federal law and a set of regulations guarantee strict confidentiality of information about all persons who seek or receive alcohol and substance abuse assessment and treatment services. The legal citations for the laws and regulations are 42 U.S.C. §290dd2 and 42 CFR Part 2. (Citations below in the form "§2..." refer to specific sections of 42 CFR Part 2.)

The Federal law and regulations are designed to protect clients' privacy rights in order to attract people into treatment. The regulations restrict communications tightly; unlike either the doctor-patient or the attorney-client privilege, the substance abuse treatment provider is prohibited from disclosing even the client's name. Violating the regulations is punishable by a fine of up to $500 for a first offense or up to $5,000 for each subsequent offense (§2.4).

The Federal rules apply to any program that specializes, *in whole or in part*, in providing treatment, counseling, or assessment and referral services for people with alcohol or drug

problems (42 CFR §2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding coming (in whole or in part) from the Federal Government. Whether the Federal regulations apply to a particular program depends on the kinds of services the program offers, not the label the program chooses. Calling itself a "prevention program" or "outreach program" or "screening program" does not absolve a program from adhering to the confidentiality rules.

In the wake of the HIV/AIDS pandemic, many States have adopted laws protecting HIV/AIDS information. These laws are designed to encourage people at risk for HIV/AIDS to be tested, determine their HIV/AIDS status, begin medical treatment early, and change risky behaviors. Many State laws were passed with the concern that those who are seropositive will suffer discrimination in employment, medical care, insurance, housing, and other areas if their status becomes known. (Other State laws protect information about individuals' health, mental health status, or treatment, as well as information about other infectious diseases.)

The primary aim of confidentiality rules is to allow the client (and not the provider) to determine when and to whom information about medical or mental health, substance abuse, or HIV infection will be disclosed. Most of the nettlesome problems that may crop up under the State and Federal laws and regulations can be avoided through planning ahead. Familiarity with the rules will ease communication. It can also reduce the confidentiality-related conflicts among program, client, and outside agency or person to a few relatively rare situations.

General rules pertaining to confidentiality

Federal protections for substance abuse-related information

The Federal confidentiality law and regulations protect any information about a client who has applied for or received any service related to substance abuse treatment from a program that is covered under the law. Services can include screening, referral, assessment, diagnosis, individual counseling, group counseling, or treatment. The regulations are in effect from the time the client applies for or receives services or the program first conducts an assessment or begins to counsel the client. *The restrictions on disclosure apply to any information that would identify the client as an alcohol or drug abuser, either directly or by implication.* They also apply to former clients or patients. The rules apply whether or not the person making an inquiry about the client already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant. It should be noted, however, that if the person requesting information has a "special authorizing court order," he does have the right to receive confidential information according to 42 CFR, Part 2.[1]

State protections for HIV/AIDS-related information

Whereas the Federal confidentiality rules apply throughout the country, each State has a different set of rules regarding disclosure of HIV/AIDS information. When substance abuse treatment programs hold HIV/AIDS-related information about clients, that information is protected by the Federal confidentiality regulations as well as by State law protecting HIV/AIDS-related information.

State protections for other medical and mental health-related information

State laws also offer general protection to some medical and mental health information. While any HIV/AIDS-specific confidentiality law is likely to be more stringent, providers should be aware of these more general statutes.[2] When may confidential information be shared with others?

Although Federal and State law protect information about clients, the laws do contain exceptions. The most commonly used exception is the client's written consent. Although the Federal law protecting information about clients in substance abuse treatment and State laws protecting HIV/AIDS-related information both permit a client to consent to a disclosure, the consent requirements are likely to differ. Therefore, whenever providers contemplate making a disclosure of information about a client in substance abuse treatment who is living with HIV/AIDS, they must consider both Federal and State laws.

Federal Rules About Consent

The Federal regulations regarding consent are strict, somewhat unusual, and must be carefully followed. A proper consent form must be in writing and must contain *each* of the items below (§2.31):

The name or general description of the program(s) making the disclosure

- The name or title of the individual or organization that will receive the disclosure
- The name of the client who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition upon which the consent expires if not previously revoked
- The signature of the client
- The date on which the consent is signed

A general medical release form, or any consent form that does not contain all of the elements listed above, *is not acceptable*. (See sample consent form in Figure 9-1.) Most disclosures of information about a client in substance abuse treatment are permissible if

the client has signed a valid consent form that has not expired or been revoked. (One exception to this statement may be when a client's file contains HIV/AIDS information, as discussed below.)

Items 4 through 7 in the above list deserve further explanation and are discussed in the sections that follow. Two other issues are also considered: the required notice to the recipient of the information that it may not be disclosed and the effect of a signed consent form.

Purpose of the disclosure and how much and what kind of information will be disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to the information necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It is improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

A key step in completing the consent form is specifying the purpose or need for the communication of information. Once the purpose has been identified, it is easier to determine how much and what kind of information will be disclosed and to tailor it to what is essential to accomplish that particular purpose or need.

Client's right to revoke consent

Federal regulations permit the client to revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to retrieve the information it has already disclosed.

Expiration of consent form

The Federal rules require that the consent form contain a date, event, or condition on which it will expire if not previously revoked. A consent form must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). If the purpose of the disclosure is expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period. It is best to determine how long each consent form should run rather than impose a set time period such as 60 or 90 days. When uniform expiration dates are used, agencies can find themselves in a situation requiring disclosure, after the client's consent form has expired. This means at the least that the client must return to the agency to sign a new consent form. At worst, the client has left or is unavailable (e.g., hospitalized), and the agency will not be able to make the disclosure.

The consent form need not contain a specific expiration date, but may instead specify an event or condition. For example, a form could expire after a client has seen a specific referred health care provider, or a consent form permitting disclosures to an employer

might expire at the end of the client's probationary period.

The signature when the client is a minor (and the issue of parental consent) [3]

Minors must always sign the consent form in order for a program to release information, even with a parent's or guardian's consent. The program must obtain the parent's signature in addition to the minor's signature only if the program is required by State law to obtain parental permission before providing treatment to minors (§2.14). ("Parent" includes parent, guardian, or other person legally responsible for the minor.)

In other words, if State law does not require the program to obtain parental consent to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to a minor, then parental consent is required to make any disclosures. *The program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone*. Substance abuse treatment programs should consult with their Single State Authority or a local lawyer to determine whether they need parental consent to provide services to minors. For more information about minors, see TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999A), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999b).

Required notice against redisclosing information

Once the consent form is properly completed, one last requirement remains. Any disclosure made with client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient of the information cannot further disclose it unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from re-releasing information except as permitted by the regulations. (Of course, a client may sign a consent form authorizing such a redisclosure.)

Note on the effect of a signed consent form

Programs may not disclose information when a consent form has expired, is deficient, is invalid or has been revoked (§2.31(c)). The other rules about how programs should respond to a signed consent form depend upon whether the disclosure will be to a third party or to the client himself and whether the client is a minor.

Disclosures to third parties

Programs subject to the Federal confidentiality rules are not required to disclose information *to a third party* about a client who has signed a consent form authorizing release of information unless the program has *also* been served with a subpoena or court

order that meets the requirements of §2.3(b) and §2.61(a)(b). If the client consenting to disclosure is a minor (an issue governed by State law), the same rule applies. However, whether a consent form signed by a minor is valid depends upon whether State law permits a minor to enter treatment without parental consent. If State law permits a minor to enter treatment without parental consent, the program can rely on the minor client's signature on the consent form to make a disclosure to a third party. If State law requires parental consent for minors to enter treatment, then the program must get the signature of *both* parent and client. The minor must always sign the form.

Whenever a program releases information to a third party, it should disclose only what is necessary, and only as long as necessary, keeping in mind the purpose of the communication.

Disclosures to clients

If a client signs a consent form authorizing the program to disclose records *directly to the client* and *State law requires the program to honor such a request*, then the program must release the records *to the client.* (Note that the Federal law does not require clients to sign a proper consent form to obtain their own records, but State law may.) If the client signing the consent form authorizing release of information is a minor and the disclosure will be to his parent, guardian or other person or entity legally responsible for him, the program should make the disclosure. State law may mandate the disclosure and once the minor has consented, the program must follow the State rule. Even in States without such a rule mandating disclosure, only extraordinary circumstances could justify withholding information from a parent or guardian once the minor has consented to its release.

Special consent rules for clients mandated into treatment by the justice system

Substance abuse treatment programs treating clients who are involved in the criminal justice system (CJS) must also follow the Federal confidentiality regulations. However, some special rules apply when a client comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of a criminal justice proceeding.

A consent form (or court order) is still required before a program can disclose information about a client who is the subject of CJS referral. For more detailed information about consent for clients within the CJS, see TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 1995c).

State Rules About Consent

State laws that protect disclosure of HIV/AIDS-related information also contain an exception permitting most disclosures when the client consents. However, some States have strict requirements governing the content of the consent form. It is important, therefore, that programs providing substance abuse treatment to people living with

HIV/AIDS become familiar with those requirements.

Which set of rules applies when a substance abuse treatment client with HIV/AIDS consents to a disclosure? This depends on what information is to be released, as illustrated in the following examples.

Example 1. Suppose a client's file contains both substance abuse treatment information and HIV/AIDS information, and the client wants to consent to disclosure of information about substance abuse to an outside agency but not information about HIV/AIDS status. This problem could be handled in several ways:

- The federally required consent form can be drafted narrowly so that the purpose for the disclosure and the kind of information to be disclosed are limited to substance abuse treatment.
- The program can maintain a filing system that isolates substance abuse and HIV/AIDS-related information in two different "treatment" or "medical" files and discloses only information from the "treatment" file. (This solution may not be practical, however, in States that regulate how and where HIV/AIDS-related information must be charted.)
- The program can send the client's file without the HIV/AIDS-related information to the outside agency and include the following notice (with the federally required notice of the prohibition on redisclosure):

This file does not contain any information protected by section ___ of the [State] law. The fact that this notice accompanies these records is NOT an indication that this client's file contains any information protected by section ___.

Example 2. If the client wants the program to release information about his HIV/AIDS status, the answer will be different. Clearly the State's form must be used. However, if the disclosure of the client's HIV/AIDS-related information will *by implication or otherwise* reveal that the client is in substance abuse treatment, the Federal form must also be used. For example, if the Satellite City Drug and Alcohol Program is the agency releasing HIV/AIDS-related information with a client's consent, the fact that the information came from a substance abuse treatment program will alert the recipient that the client is not only HIV positive but is also in substance abuse treatment. The program, therefore, must use a consent form that complies with both Federal and State requirements. It should not be necessary for clients to sign two separate forms in this kind of situation; a form that complies with both sets of requirements should be drafted.

Example 3. Finally, what happens when a client signs a proper consent form permitting disclosure of information about her substance abuse treatment, and the information she consents to release would also disclose her HIV/AIDS status? Can the program release the information? Not unless the program has complied with State consent requirements. Even if a client has signed a consent form permitting disclosure of substance abuse information, the program may not release information about HIV/AIDS unless it has also

satisfied State requirements.

Strategies for Communication With Others About Clients

Some of the practical questions that affect program operations include the following:

- How can substance abuse treatment providers seek information from collateral sources about clients they are screening, assessing, or treating?
- How can providers comply with State mandatory reporting laws?
- How should providers deal with insurance companies and other third-party payors?
- How can providers respond to requests for information about clients who have died or become incompetent?
- How should programs deal with clients' risk-taking behavior? Do programs have a duty to warn potential victims or law enforcement agencies of clients' threats to plan to infect someone else with HIV/AIDS, and if so, how do they communicate the warning?
- Can staff members of substance abuse treatment programs comply with mandatory State child abuse reporting laws?

Seeking information from collateral sources

Making inquiries of family members, employers, schools, doctors, and other health care entities might seem to pose no risk to a client's right to confidentiality. This is not the case. When program staff seek information from other sources, they are letting these sources know that the client has asked for substance abuse treatment services. The Federal regulations generally prohibit this kind of disclosure unless the client consents.

How should a substance abuse treatment program proceed? The easiest way is to obtain the client's consent to contact the employer, family member, school, health care facility, etc. Or, the program could ask the client to sign a consent form that permits it to make a disclosure for the purpose of seeking information from other sources to any one of a number of organizations or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or the name of the organization" for each source the program contacts. Whichever method the program chooses, it must use the consent form required by the regulations, not a general medical release form.

If the client is living with HIV/AIDS, the program must check State laws to see whether they impose additional requirements. For example, an alcohol and drug counselor wishing to talk to a client's primary care physician must first find out whether State law protecting HIV/AIDS-related information requires that additional provisions be added to the consent form the client signs.

Making mandatory reports to public health authorities

All States require that AIDS and tuberculosis (TB) be reported to public health

authorities, and some States also require that new cases of HIV infection be reported. The reports are forwarded to the Centers for Disease Control and Prevention (CDC). All States also use the TB report to perform contact tracing, or finding others to whom an infected person may have spread the disease; some States use HIV/AIDS reporting similarly.

In each State, what must be reported for which diseases, who must report, and the purposes for which the information is used vary. Therefore, providers must be familiar with their State laws regarding (1) whether they or any of their staff members are mandated to report, (2) when reporting is required, (3) what information must be reported and whether it includes client-identifying information, and (4) what will be done with the information reported.

Reporting HIV/AIDS and TB cases

If client-identifying information must be reported, how can programs comply with State laws mandating the reporting of TB and HIV/AIDS cases? Several ways are listed below.

Reporting with consent

The easiest way to comply is to obtain the client's consent. Note that if the public health authority plans to redisclose the information to the CDC, the consent form must be drafted to permit such redisclosure. The consent form can also be drafted to authorize the program to communicate on an ongoing basis with the public health department to help them find, counsel, monitor, or treat a client or coordinate a client's TB care.

Reporting without making a client-identifying disclosure

If State law permits the use of a code rather than the client's name, the program can make the report without the client's consent because no client-identifying information is being revealed. If the program is part of another health care facility, general hospital, or a mental health program, the report can include the client's name, if it does so under the name of the parent agency and releases no information that links the client with substance abuse treatment. (See the discussion below in "Communications that do not disclose client-identifying information.") Reporting through a Qualified Service Organization Agreement

A substance abuse treatment program can enter into a Qualified Service Organization Agreement (QSOA) with the State or local public health department charged with receiving mandatory reports. The QSOA (explained in more detail later in this chapter) permits the program to report names of clients to the health department and, if properly drafted, allows ongoing communication between the program and public health officials.

A program that is required to report TB or AIDS cases to a public health department can also enter into a QSOA with a general medical care facility or a laboratory that conducts

testing or provides care to the program's clients. The QSOA would permit the program to report the names of clients to the medical care facility or laboratory, which can then report the information (including the clients' names) to the public heath department, without any information that would link those names with substance abuse treatment. Note that State confidentiality laws might impose additional requirements. Also, an agreement with a medical care facility or laboratory would not permit public health authorities to follow up on cases with the treatment program.

Reporting under the audit and evaluation exception

One exception to the general rule prohibiting disclosure without a client's consent permits programs under certain conditions to disclose information to auditors and evaluators (§2.53). (For an explanation of the requirements of §2.53, see TIP 14, Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment [CSAT, 1995a].) DHHS has written two opinion letters that approve the use of the audit and evaluation exception to report HIV/AIDS-related information to public health authorities (see Pascal, 1988, and Zagame, 1989). Together, these two letters suggest that substance abuse treatment programs may report client-identifying information even if that information will be used by the public health department to conduct contact tracing, so long as the health department does not disclose the name of the client to "contacts" it approaches. The letters also suggest that public health authorities could use the information to contact the infected substance abuse disorder client directly.

However, some authorities may not agree with these opinion letters. As its title "audit and evaluation" implies, §2.53 is intended to permit an outside entity, such as a peer review organization or an accounting firm, to examine a program's records to determine whether it is operating appropriately. It is not intended to permit an outside entity such as the public health authority to gain information for other social ends, such as tracing the spread of disease. It can be argued that such use distorts the purpose of the audit and evaluation exception.

Getting a court order

A program could apply to a court for an order authorizing it to disclose information to a public health department. The court order provision is discussed further under "Exceptions that permit disclosures," below. Since obtaining a court order requires drawing up legal papers, it is not likely to be a program's first choice.

Using the medical emergency exception

The Federal regulations permit a program to disclose information without client consent to medical personnel "who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health" of the client or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51). (This exception is explained more fully later in this chapter.) Because any disclosure under this

exception is limited to true emergencies, a program cannot routinely use the medical emergency exception to make mandatory reports. Because immediate medical intervention is unlikely to prevent or cure HIV infection, it is not an advisable way to make mandatory HIV/AIDS reports to public health departments.

For a more complete exploration of these options see TIP 18, *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers* (CSAT, 1995d).

Dealing with client risk-taking behavior

Does a program have a "duty to warn" others when it knows that a client is infected with HIV? When would that "duty" arise? Even where no duty exists, should providers warn others at risk about a client's HIV status? Finally, how can others be warned without violating the Federal confidentiality regulations and State confidentiality laws?

These questions raise complex legal issues that are discussed below. But first it must be noted that "warning" someone about a client's HIV status without his consent has potential consequences. Successful substance abuse treatment depends on clients' willingness to expose shameful things about themselves to program staff. The news that the program has "warned" a spouse, lover, or someone else that a client is HIV positive will spread quickly among the client population. Such news could destroy clients' trust in the program and its staff. Any counselor or program considering "warning" someone of a client's HIV status without the client's consent should carefully analyze whether there is, in fact, a "duty to warn" and whether it is possible to persuade the client to discharge this responsibility himself or consent to the program's doing so.

Is there a duty?

The answer is a matter of State law. Courts in some States hold that health care providers have a duty to warn third parties of behavior of persons under their care that poses a potential danger to others. In addition to these court decisions, some States have laws that either permit or require health care providers to warn certain third parties. Usually, these State laws prohibit disclosure of the infected person's identity but allow the provider to tell the person at risk that she may have been exposed. It is important that providers consult with an attorney familiar with State law to learn whether the law imposes a duty to warn, as well as whether State law prescribes the ways a provider can notify the person at risk. The law in this area is still developing and may expand; thus, it is important to keep abreast of changes. One source of information about State codes with regard to the duty to warn is each State's Web site (available at http://janus.state.me.us/states.htm). (If there is no State statute or court decision on this issue, it is best to consult with a lawyer or someone with expertise in this area who can help the program determine the best course to take. Such a consultation is particularly helpful because of the competing obligations the program may have to protect a third party who may be in danger and to safeguard its client's confidentiality.)

When does the duty arise?

Two behaviors of infected persons can put others at risk of infection: unprotected sex involving the exchange of bodily fluids and syringe sharing. Because HIV is not transmitted by casual contact, the simple fact that a client is infected would not give rise to a duty to warn the client's family or acquaintances who are not engaged in sex or syringe sharing with the client.

This still leaves open the question as to when duty arises. Is it when a client tells a counselor that he wants to or plans to infect others? Or when a client tells the counselor that he has already exposed others to HIV? These are two different questions.

Threat to expose others

A counselor whose client threatens to infect others should consider four questions in determining whether there is a "duty to warn":

- Is the client making a threat or "blowing off steam?" Sometimes, wild threats are a way of expressing anger. However, for example, if the client has a history of violence or of sexually abusing others, the threat should be taken seriously.
- Is there an identifiable potential victim? Most States that impose a "duty to warn" do so only when there is an identifiable victim or class of victims. However, unless public health authorities have the power to detain someone in these circumstances there is little reason to inform them.
- Does a State statute or court decision impose a duty to warn in this particular situation?
- Even if there is no State legal requirement that the program warn an intended victim or the police, does the counselor feel a moral obligation to do so?

Clearly, there are no definitive answers in this area. Each case depends on the particular facts presented and on State law. If a provider believes she has a "duty to warn" under State law, or that there is real danger to a particular individual, she should do so in a way that complies with both the Federal confidentiality regulations and any State law or regulation regarding disclosure of medical or HIV/AIDS-related information. Because a client is unlikely to consent to disclosure to the potential victim, to comply with the Federal regulations a provider could act as follows:

Seek a court order authorizing the disclosure. The program must take care that the court abide by the requirements of the Federal confidentiality regulations, which are discussed below in detail. It should also consult State law to determine whether it imposes additional requirements.

Make a disclosure that does not identify the person as a client in substance abuse treatment. This can be accomplished either by making an anonymous report or, for a program that is part of a larger nonsubstance abuse treatment facility, by making the report in the larger facility's name. Counselors at freestanding alcohol or drug programs cannot give the name of the program. (Non-client-identifying

disclosures are discussed more fully under "Exceptions that permit disclosure," below.)

In these circumstances, the counselor should also limit the way he makes the warning to minimize the exposure of the client's identity as HIV positive.

Recounting an exposure

Suppose an HIV-infected client tells his counselor that he has had unprotected sex or shared syringes with someone. If the counselor knows who the person is, does she have a "duty to warn" that person (or law enforcement)? This is not a true duty to warn case because the exposure has already occurred. The purpose of the "warning" is not to prevent a criminal act but to notify an individual so that she can take steps to monitor health status. Thus, it is probably not helpful to call a law enforcement agency. Rather, the counselor might want to let the public health authorities know, particularly in States with mandatory partner notification laws. Public health officials can then find the person at risk and provide appropriate counseling.

How can programs notify the public health department without violating confidentiality regulations? In some areas of the country, programs have signed QSOAs with public health departments that provide services to the program. A QSOA enables providers to report exposures to the department in situations like these. The public health department can then not only help the person the counselor believes was exposed but also trace other contacts the client may have exposed. In doing so, the public health department often does not identify the person who has put his contacts at risk. The public health department would not have to tell the contact that the person is in substance abuse treatment, and the QSOA would prohibit it from doing so. (A treatment program must also make sure that reporting an exposure by a client through a QSOA complies with any State law protecting medical or HIV/AIDS-related information.)

If the provider does not have a QSOA with the public health department, it might try one of the following methods:

Consent. The provider could inform the health department with the client's consent. The consent form must comply with both the Federal confidentiality regulations and any State requirements governing client consent to release of HIV/AIDS information, as well as any other State law governing consent (e.g., whether a parent also must consent).

"Anonymous" notification. If the program notifies the public health department in a way that does not identify the client as a substance abuser, this constitutes complying with the Federal regulations.

Court order. Again, State law must be consulted to determine whether it imposes requirements in addition to those imposed by the Federal regulations.

One of the above methods should enable the provider to alert the public health department, which is the most effective way to notify someone who may have been

exposed.

The program should document the factors that impelled the decision to warn an individual of impending danger of exposure or to report an exposure to the public health department. If the decision is later questioned, notes made at the time of the decision could prove invaluable.

As noted earlier, whenever a program proceeds without a client's consent to warn someone of a threat the client made or to report an exposure that has already occurred, the program may be undermining the trust of other clients and thus its effectiveness. This may be particularly true for a program serving HIV-positive clients. This is not to say that a disclosure should not be made, particularly when the law requires it. It is to say that a disclosure should not be made without careful thought.

Circumstances in which a "duty to warn" or "duty to notify" arises may change over time, as scientists learn more about the virus and its transmission and as more effective treatments are developed. There is little doubt that the law also will change, as States adopt new statutes and their courts apply statutes to new situations.

Programs should develop a protocol about "duty to warn" cases, so that staff members are not left to make decisions on their own about when and how to report threats or past occurrences of HIV transmission. Ongoing training and discussions can also assist staff in sorting out what should be done in any particular situation. Figure 9-2 provides a decision tree about the duty to warn.

Disclosures to insurers, HMOs, and other third-party payors

Traditional health insurance companies offering reimbursement to clients for treatment expenses require clients to sign claim forms containing language consenting to the release of information about their care. Can a program release information after a client has signed one of these standard consent forms? It cannot do so unless the form contains all the elements required by §2.31 of the regulations. Also, when the disclosure includes any HIV/AIDS-related information, the consent form must comply with State law.

Health maintenance organizations (HMOs) do not require clients to submit claim forms with language consenting to the release of information. Instead, clients in systems run by managed care organizations (MCOs) generally agree when they enter the "system" that the HMO or MCO can review records or request information about treatment at any time.

A substance abuse treatment program cannot rely on the fact that the client agreed when he signed on with the HMO that it could review his records and talk to doctors and other care providers whose fees it is covering. Federal regulations prohibit any communication unless the client has signed a proper consent form or the communication fits within another of the regulatory exceptions. State laws protecting HIV/AIDS-related information may also prohibit release of information in such circumstances.

As managed care becomes more prevalent, substance abuse treatment providers (and other professionals in the field of counseling and mental health) are finding that in order to monitor care and contain costs, third-party payors are demanding more information about clients and about the treatment provided them. The demand for information or records often comes when a provider requests authorization to continue or extend treatment. Providers are becoming all too familiar with the kinds of information they need to supply to HMOs and MCOs to obtain authorization to treat (or continue to treat) a client.

In many instances, simply getting the client's signature on a consent form that complies with the Federal rules and any State law governing the release of HIV/AIDS-related information will not resolve the ethical dilemma raised by the demand for greater and more detailed information. Providers faced with the question, "To disclose or not to disclose?" can be torn between their client's real need for continued treatment and the client's right to privacy. Should the provider disclose all information the HMO requests, perhaps shading it to ensure authorization, or should the provider protect the client's privacy, thereby jeopardizing the client's opportunity to obtain needed treatment services?

The better practice is to discuss the dilemma frankly with the client and to allow the client to decide whether and how much to disclose. To make an informed decision, the client will have to know what information the provider is being asked to disclose to obtain authorization to treat or continue treatment. The client and provider should discuss the likely consequences of the alternatives open to the client--disclosure and refusal to disclose. The client should understand that disclosure of the information the HMO seeks may be the only way to get the HMO to cover his treatment. Refusal to comply with the request for information will likely result in the HMO's refusal to cover at least some of the services the client needs.

On the other hand, the client may be more concerned that once his insurer learns she has a substance abuse problem or is HIV positive, she will lose her insurance coverage and be unable to obtain other coverage. For example, if in response to a demand from an HMO the provider releases information that the client's substance abuse has included use of both alcohol and illegal drugs, the HMO may deny benefits, arguing that since its policy does not cover treatment for abuse of drugs other than alcohol, it will not reimburse treatment when abuse of both alcohol and drugs is involved. A client whose employer is self-insured may fear being fired, demoted, or disciplined if the employer suspects he has abused substances or is HIV positive.

The process of helping the client weigh the available choices allows the client to make a decision based on his understanding of his own best interests.

Even a decision as simple as whether to submit a claim for HIV testing should be preceded by a discussion about the pros and cons of requesting coverage from an insurance company or HMO. The insurance company or HMO may infer from the fact that the client has had a test that he has engaged in risky behavior.

A client who fears the loss of employment or insurance may decide to pay for HIV testing or substance abuse treatment out of pocket. Or she may agree to a limited disclosure and ask the provider to inform her if more information is requested. If a client does not want the insurance carrier or HMO to be notified and is unable to pay for treatment, the program may refer her to a publicly funded program, if one is available. Programs should consult State law to learn whether they may refuse to admit a client who is unable to pay and who will not consent to the necessary disclosures to her insurance carrier.

Disclosing information about clients who have died or become incompetent

The Federal regulations apply to any disclosure of information that would identify a deceased client as a substance abuser, and programs may not release information unless an executor, administrator, or other personal representative appointed under State law has signed a consent form authorizing the release of information. If no such appointment has been made, the client's spouse, or if there is no spouse, any responsible member of the client's family can sign a consent form (§2.15(b)(2)). An exception is that the regulations do permit a program to disclose client-identifying information that relates to a client's cause of death pursuant to laws requiring the collection of death or other vital statistics or permitting an inquiry into the cause of death (§2.15(b)(1)).

How can programs handle disclosures about incompetent clients? If the client has been adjudicated as lacking the capacity to manage his affairs, a consent form can be signed by his guardian or other individual authorized by State law to act on his behalf. If the client has not been adjudicated incompetent but suffers from "a medical condition that prevents knowing or effective action on his own behalf," the program director can sign a consent form but only for the purpose of getting payment for services from a third-party payor (§2.15(a)).

Exceptions that permit disclosures

The Federal confidentiality regulations' general rule prohibiting disclosure of client-identifying information has a number of exceptions. Reference has already been made to some of these exceptions: consent, disclosures that do not identify someone as a client in substance abuse treatment, disclosures pursuant to a QSOA, disclosures during a medical emergency, disclosures authorized by special court order, and disclosures of information to auditors. The rules governing these exceptions are described in the pages that follow. Also explained is another exception, not yet mentioned, that permits disclosure of information among program staff.

Communications that do not disclose client-identifying information

The Federal regulations permit programs to disclose information about a client if the program reveals no client-identifying information. "Client-identifying" information identifies someone as an alcohol or drug abuser. Thus, a program may disclose information about a client if that information does not identify her as an alcohol or drug

abuser or support anyone else's identification of the client as an alcohol or drug abuser.

A program may make such a disclosure in two basic ways. First, a program can report aggregate data about its population (summary information that gives an overview of the clients served in the program) or some portion of its populations. Thus, for example, a program could tell the newspaper that in the last 6 months it screened 43 clients, 10 female and 33 male.

The second way was mentioned above: A program can communicate information about a client in a way that does not reveal the client's status as a substance abuse disorder client (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as substance abuse may disclose information about a particular client as long as the fact that the client has a substance abuse problem is not revealed. More specifically, a program that is part of a general hospital could ask a counselor to call the police about a violent threat made by a client, as long as the counselor does not disclose that the client has a substance abuse problem or is a client of the treatment program.

Programs that provide only alcohol or drug services cannot disclose information that identifies a client under this exception--letting someone know a counselor is calling from the "Capital City Drug Program" automatically identifies the client as someone who received services from the program. However, a free-standing program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as an alcohol or drug abuser.

Programs using this exception to disclose HIV/AIDS-related information about a client must also consult State law to determine if this kind of disclosure is permitted.

Disclosures to an outside agency that provides services to the program: QSOA

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a *qualified service organization agreement*, or "QSOA." This is a written agreement between a program and a person providing services to the program, in which that person

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, she is fully bound by the Federal confidentiality regulations
- Promises that, if necessary, she will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§2.11, §2.12(c)(4))

A sample QSOA is provided in Figure 9-3. A QSOA should be used only when an agency or official outside of the program provides a service to the program itself. An example is when laboratory analyses or data processing are performed for the program by

an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information needed by others so that the program can function effectively. QSOAs may not be used between programs providing alcohol and drug services. Programs that share information with outside agencies by using the QSOA must take care that any information about HIV/AIDS or other infectious diseases is transmitted in accordance with State law.

Medical emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health" of the client or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits only disclosure to medical personnel. This means that this exception cannot be used as the basis for a disclosure to family, the police, or other nonmedical personnel.

Whenever a disclosure is made to cope with a medical emergency, the program must document the following information in the client's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency

Programs using the medical emergency exception to disclose information about a client's infectious disease or infection with HIV must also consult State law to determine if a disclosure is permitted.

Disclosures authorized by court order

A State or Federal court may issue an order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information* (§2.61).

Before a court can issue a court order authorizing a disclosure about a client, the program and any clients whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court. (However, if the information is being sought to investigate or prosecute a client for a crime, only the

program need be notified (§2.65). Also, if the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).) Generally, the application and any court order must use fictitious names for any known client, and all court proceedings in connection with the application must remain confidential unless the client requests otherwise (§2.64(a), (b), §2.65, §2.66). Before issuing an authorizing order, the court must find "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the client, or the doctor-patient or counselor-client relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

There are also limits on the scope of the disclosure a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§2.64(e)).

> The court may order disclosure of "confidential communications" by a client to the program only if the disclosure
> Is necessary to protect against a threat to life or of serious bodily injury
> Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
> Is in connection with a proceeding at which the client has already presented evidence concerning confidential communications (e.g., "I told my counselor_") (§2.63)

Again, programs using the court order exception to disclose identity or HIV/AIDS information about a client must also consult State law to determine if a disclosure is permitted. Research, audit, or evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (§2.52, §2.53). For a more complete explanation of the requirements of §2.52 and §2.53, see Chapter 6 of TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* (CSAT, 1995a).

Again, State law must be consulted to see that any audit that inspects HIV/AIDS information about a client is conducted in accordance with State law.

Internal program communications

The Federal regulations permit some information to be disclosed to staff members within the same program:

The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)).

In other words, staff who have access to client records because they work for or administratively direct the program, "including full-or part-time employees and unpaid volunteers," may consult among themselves or otherwise share information if their substance abuse treatment work so requires (§2.12(c)(3)). After consent, this is the most commonly invoked exception.

Some States have enacted laws that restrict the staff who are permitted access to HIV/AIDS-related information. Programs should consult a lawyer familiar with State law and implement a policy that complies with any restrictions on staff access to this information.

Other rules regarding confidentiality

Client notice

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to clients when they begin participating in the program or soon thereafter (§2.22(a)). The regulations contain a sample notice.

Client access to records

Programs can decide when to permit clients to view or obtain copies of their records, unless State law grants clients the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records. Programs serving clients living with HIV/AIDS should educate themselves about any State laws or regulations requiring notice to clients and access to records.

Security of records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container. The program should establish written procedures that regulate access to and use of client records. Either the program director or a single staff person should be designated to process inquiries and requests for

information (§2.16).

Computerization of medical and treatment records complicates the problem of keeping sensitive information private. Currently, protection is afforded by the cumbersome and inefficient paper files that many, if not most, medical, mental health, and social services still store and send from one provider to another. When records are stored in computers, retrieval can be far more efficient, but computerized records may allow anyone with access to the computer in which the information is stored to copy information without constraint or accountability. Modems that allow communication about clients among different components of a managed care network extend the possibility of unauthorized access. The ease with which computerized information can be accessed can lead to casual gossip about a client, particularly if it is someone of importance in the community, making privacy difficult to preserve. For a brief discussion of some of the issues that computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT, 1996), pp. 52(53.

Conclusion

For providers of substance abuse treatment to clients living with HIV/AIDS, the rules regarding confidentiality of clients' information are very specific. State laws address disclosure of HIV/AIDS-related information as well as other medical and mental health information. Overlaid on these are the Federal law and regulations regarding confidentiality of substance abuse treatment information.

Generally, no more than two sets of laws apply in any given situation. If only substance abuse treatment information will be disclosed, a program is generally safe in following Federal rules. If HIV/AIDS-related information will be disclosed, and the disclosure will reveal the client is in drug treatment, the program must comply with both sets of laws. When in doubt, the best practice is to follow the more restrictive rules. Whenever possible, providers should try to find resources familiar with State laws to help sort out their responsibilities. The State Department of Health, the Single State Authority, the State Attorney General, professional associations, a member of the agency's board who is an attorney, advocacy groups for people living with HIV/AIDS, or a local law school or bar association might provide the necessary information.

End Notes

[1.] If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a client for a crime, the court must also find that (1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or

potential harm to the client.

[2] For a discussion of these kinds of State confidentiality laws, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997), Appendix B.

[3] There is an exception that allows the director of a substance abuse treatment program to communicate with a minor's parents without the minor's consent, when (1) the minor is applying for services; (2) the program director believes that the minor, because of extreme substance abuse or medical condition, does not have the capacity to decide rationally whether to consent to the notification of her parents or guardian; and (3) the program director believes that the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else. Thus, if a minor applies for services in a State where parental consent is required to provide services, but the minor refuses to consent to the program's notifying his parents or guardian, the regulations permit the program to contact a parent without the minor's consent, if these conditions are met. Otherwise, the program must explain to the minor that although he has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent (§2.14(d)). The regulations add a warning, however, that such action might violate a State or local law (§2.14(b)).