

# *Ethical and Confidentiality Issues in Substance Abuse Treatment*

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Faith Based Training Series

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# Training Roadmap

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- What are the ethical issues we face as providers?
- What are the confidentiality issues we face as providers?
- How do we best deal with client crisis and difficult patients?

# ETHICS (1)

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- **Ethics codes are laws that guide professionals in helping clients in a fair, respectable, objective, and humane way**
- **Personal values guide moral conduct appropriate for work settings**
- **Understanding the connection between law and ethics and feeling a responsibility to integrate both appropriately**

# ETHICS (2)

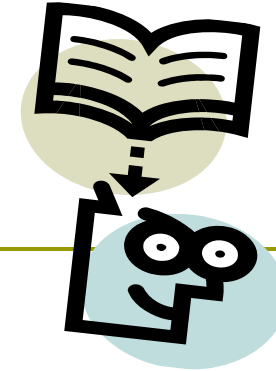
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- **Ethical principles establishes a higher standard of conduct than is required by law; as mental health and/or substance abuse treatment providers we hold ourselves/our professions to a higher ethical standard.**
- **Ethical principles and morality delineate what feels “right” or “good.”**

# ETHICS (3)

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- ❑ Ethical behavior requires more than a familiarity with laws and the profession's code of ethics.
- ❑ Need to develop a personal ethical sense that involves reflection and insight in assuring the best possible service deliver to their clients.
- ❑ Need to be sensitive to the moral dimensions of counseling. This includes not only professional ethics, but also personal principles and philosophy consistent with the profession

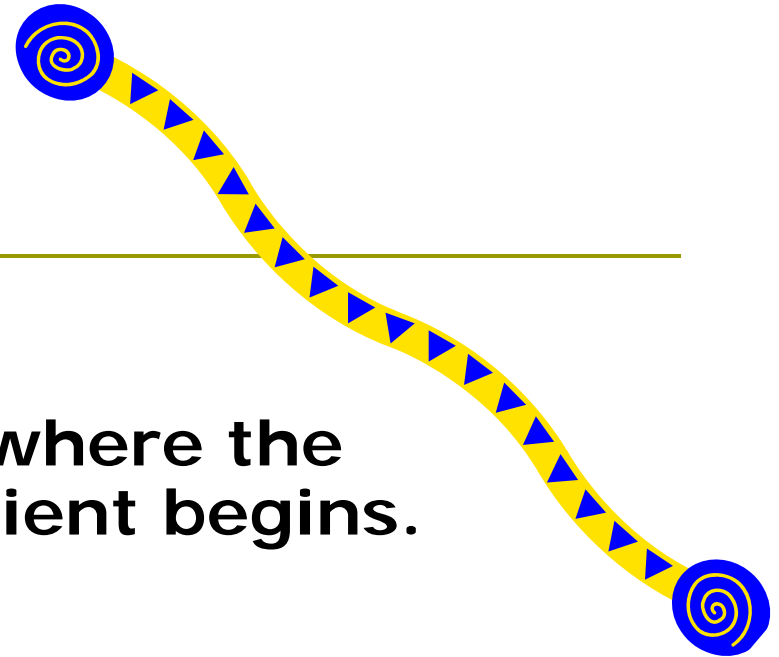
# ETHICS (4)

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- **Examination of the relevant federal and state regulations and case law for guidance.**
- **Understanding your agencies policies and procedures for client services (conflict of interest, referrals, chain of command, roles, responsibilities)**
- **Awareness of personal needs/issues relevant to the provision of mental health care/drug treatment services to others (personal relapse, mental health, family issues)**

# PROFESSIONAL BOUNDARIES (1)

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- **The line that separates where the provider ends and the client begins.**
- **The emotional and physical line that gives our clients space to focus on themselves - not on us.**
- **The limits that control the professional's power so that clients are not hurt.**

# PROFESSIONAL BOUNDARIES (2)

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- **Dictate our interactions with clients.**
- **Have some fluidity depending on the client's vulnerability and our role.**
- **Are parameters that keep the professional as objective as possible.**





# QUESTION:

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**What are some examples of Boundary Issues you have faced?**

# QUESTION:

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**Whose Job Is It To  
Maintain Professional  
Boundaries?**

# How do we Maintain Professional Boundaries?

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- **Provider's responsibility to maintain professional boundaries:**
  - **Set proper limits**
  - **Maintain a treatment focus**
  - **Be aware of thoughts/feelings generated by the client, or about the client**
  - **Seek supervision – know what to do with these feelings.**

# QUESTION:

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**What do I do about thoughts/feelings I may be having about a client?**

**How do I handle thoughts/feelings without inappropriately involving the client ?**

What if a client wants a  
different kind of  
relationship?

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# HOW TO HANDLE CLIENTS WHO WANT A DIFFERENT TYPE OF RELATIONSHIP?

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- **Set firm limits**
- **Explain why you are setting the limits**
- **Try not to be rejecting as you set clear limits**

# Dual or Multiple Relationships?

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- **A situation where the professional (provider) functions in more than one role with the client.**
  - **Can create confusion of roles**
  - **Can make setting limits difficult**

# Social / Friendship Relationships?

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- **A situation where the professional (provider) decides that it is acceptable to see a client (or former client) in a social context or decides that it is acceptable to now “be friends” with the client.**



# Business / Bartering Relationships?

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- ❑ **A situation where the professional (provider) engages in a business relationship or trading services with a client.**

# Gift-Giving?

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- **A counselor is appreciated for what she/he does...written note, verbal expression of thanks, or a material token of appreciation?**
  - **Does refusing such gifts reject or insult the client?**
  - **Why should we carefully consider in advance any type of gift given?**

# Counseling to Family or Friends?

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- **A situation where the professional (provider):**
  - **Agrees to “talk” with a family member or friend (on a regular basis) who really needs treatment but can’t or won’t seek it out;**
  - **Agrees to provide treatment in a situation where the family member or friend *does* want treatment, but would rather “talk” to her/him because she/he trusts you already, and you know their background;**
  - **Agree to provide treatment for a friend or family member.**

# Romantic / Sexual?

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- **A situation where the professional (provider) begins to view the client as a potential romantic partner, fantasizes about the client, thinks about terminating treatment so that the relationship can “deepen”; engaging in a sexual relationship with client/other staff person.**

# Sexual Relationships: Legal and Ethics Issues (1)

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- ❑ Never engage in any form of sexual contact with a client.
  
- ❑ Sexual contact can include:
  - intercourse, anal or oral sex, fondling, and any other kind of sexual touching.
  
  - nudity, kissing, spanking, verbal suggestions, innuendoes, or advances.
  
  - This kind of behavior is considered exploitation by the health care provider.

# Sexual Relationships: Legal and Ethics Issues (2)

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- ❑ Sexual relations with a client is illegal in all 50 states.
- ❑ Sexual relations with a client is potentially harmful, at the least
- ❑ New code allows for client-counselor relations a minimum of 5 years after termination of professional relationship (law vs. ethics?)
- ❑ Reminder: Do No Harm.

# Sexual Relationships: Legal and Ethics Issues (3)

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- ❑ **Loss of objectivity to provide appropriate treatment or exercise appropriate judgment**
- ❑ **Ethics code for helping professions – unprofessional conduct, unethical, illegal**
- ❑ **Damage to the client's mental health**
- ❑ **Loss of trust in the helping professions for Ct.**
- ❑ **Ct. focus is on you rather than on him/herself**
- ❑ **May become confused about motivations to change (e.g., desire to keep the relationship going)**

# PRACTICE

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- **Form Small Groups. Develop a detailed vignette that involves a “gray area” ethical dilemma between a provider and client.**

**Groups will trade vignettes and discuss approaches for best handling the situation.**



# SELF DISCLOSURE: WHEN IS IT OK?





# THINGS TO CONSIDER?

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- **Why** are you disclosing the information?
- **What** will the information mean to the client?
- Are you okay with **EVERYONE** in the clinic knowing the information?



# THINGS TO CONSIDER?

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- ❑ Should you **respond** to client's personal questions about your past/present experience with \_\_\_\_\_ ?
- ❑ Should you self disclosed once the therapeutic relationship has been **harmed** in some way?
- ❑ Is there **another way** to accomplish your goal without personal disclosure?

# WHY ARE YOU DISCLOSING?

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- **What is your goal in providing the client with this information?**
- **Are you sure that it is meeting a client need and not a personal need?**



# WHAT WILL THE INFORMATION MEAN TO THE CLIENT?

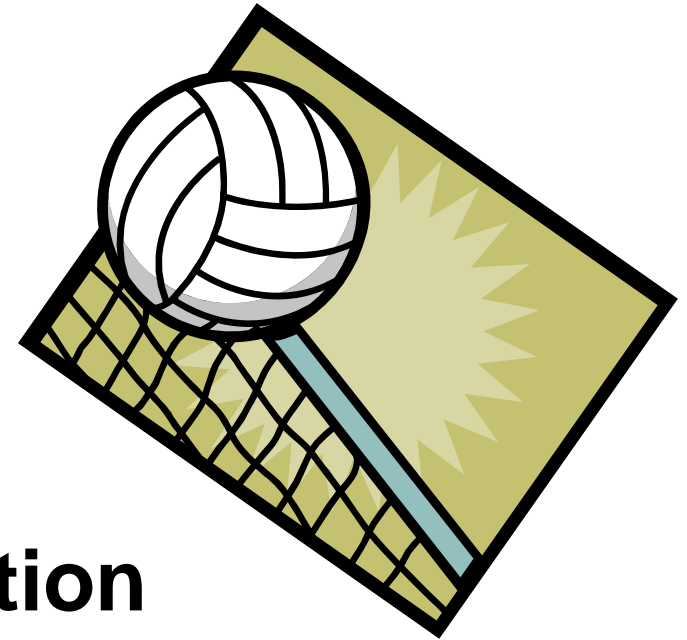
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- **How will the client interpret what you are saying?**
- **Are you sending confusing messages?**
- **Are you okay with everyone knowing?**
- **Will the information later be used against you?**

# IS THERE ANOTHER WAY TO ACCOMPLISH YOUR GOAL?

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- **Alternate Strategies?**
  - **Deflect**
  - **Redirect**
  - **Answer another question**
  - **Use the third person**



# PRACTICE

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- **Form Pairs and role play a provider and client.**

As the “client,” ask personal questions of the provider.

As the “provider,” practice the above skills (e.g., deflection, redirection).

**How was that for you?**

**What did you learn?**

# Confidentiality Issues in Substance Abuse Treatment





# Confidentiality and Treatment (1)

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Confidentiality is necessary because without that guarantee, many individuals with substance abuse problems would be reluctant to participate fully in treatment programs.

# Confidentiality and Treatment (2)

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- The client's rights and the limits of confidentiality should be explained at the beginning of treatment
- Client information should not be communicated outside of the treatment team
- Information should only be released with the client's or guardian's permission

# Areas of Possible Confidentiality

## Dilemmas:

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- ❑ Maintaining confidentiality in institutional settings
- ❑ Disclosure to client employer of danger or discipline
- ❑ Sharing client info. with family members
- ❑ 3<sup>rd</sup> party payment agencies and disclosure
- ❑ Mandated reporting: Client illness, unsafe to self and others, etc.
- ❑ Group counseling setting
- ❑ Treatment team debriefings



# Confidentiality & Privilege Communication

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Several rules apply to participants in Drug treatment courts.

- 42 CFR Part 2 – The alcohol and substance abuse treatment confidentiality rule.
- HIPAA – New federal rules covering all health related information.

# 42 CFR Part 2



The regulations governing  
confidentiality of alcohol and  
drug abuse patient records

# 42 U.S. Code 290dd

## 42 CFR Part 2

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- First issued 1975, revised 1987
- Designed to help deal with the stigma of addiction.
- Requires notification of confidentiality, consent forms, prohibition of re-disclosure

# Intent of 42 CFR Part 2

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- ❑ Insure that an alcohol or drug abuse patient is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment
- ❑ Imposes restrictions upon the disclosure and use of patient records that are maintained in connection with the performance of any federally assisted alcohol and drug abuse program

# Applicability

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- ❑ Any information (including referral and intake) about alcohol and drug abuse patients obtained by a program
- ❑ Includes (not limited to):
  - Treatment or rehab programs
  - EAP
  - Programs within a general hospital
  - School-based programs
  - Private practitioners who provide alcohol or drug abuse diagnosis, treatment or referral



# 42 CFR Part 2 Allowable Disclosures

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- ❑ Written authorization
- ❑ Internal communication (“need to know”)
- ❑ No patient-identifying information
- ❑ Medical emergency
- ❑ Qualified Service Organization
- ❑ Audit and evaluation
- ❑ Crimes (or threats of) on program premises or against program personnel
- ❑ Initial reports of suspected child abuse or neglect
- ❑ Court order meeting specifications of 42
- ❑ Research

# More interesting 42 CFR Part 2 facts

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- ❑ Applies even if the person seeking the information already has it or has other ways to obtain it
- ❑ Applies to law enforcement or other official, even with a subpoena
- ❑ Disclosing the presence of a patient at a facility which is identified as a place where only drug/alcohol services are provided requires written authorization
- ❑ A payer or funding source that maintains records of a recipient of drug/alcohol treatment becomes subject to 42 CFR Part 2 to the same extent as the program from which the information came.

# Clarifying 42 CFR Part 2

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- ❑ Some believe that physicians and case managers cannot access any information about an individual's substance use.
- ❑ Others believe that substance use disorder information regarding treatment covered by 42 USC 290dd and 42 CFR Part 2 is unnecessarily withheld from physicians, payers, health information exchanges, and health plans.

# Clarifying 42 CFR Part 2

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## □ BUT.....

- Current Law and Regulations Allow Use of Information for Coordination of Care and Quality Oversight

# Clarifying 42 CFR Part 2

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The restrictions on disclosure in these regulations do not apply to communications between a program and a **qualified service organization** of information needed by the organization to provide services to the program.

Source: 42 CFR § 2.12 (c)(4)

# Qualified Service Organization (QSO)

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Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

Source: 42 CFR § 2.11

# QSO Written Agreement

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- A written agreement with a program under which that person:
  - (1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and
  - (2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Source: 42 CFR § 2.11

# HIPAA





# HIPAA

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- ❑ Health Insurance Portability and Accountability Act of 1996
- ❑ Designed to ensure maintenance of health insurance coverage when you change jobs.
- ❑ Administrative simplification – Healthcare processes becoming very complex – look to standardize information – make it easier.
- ❑ Protect confidentiality and security of patient information

# Protected Health Information

## 2 Components

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- ❑ Identifies the client
- ❑ Health Information
- ❑ Any information that is oral, written, electronic, created or received by health care provider, health plan, public health authority, employer, insurer, or others
- ❑ Relating to past, present or future physical or mental health status, health care, and payment for such services

## Notice of Privacy Practices (NPP)

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- ❑ PATIENT RIGHTS
- ❑ Right to request restriction of uses and disclosures of information
- ❑ Right to access PHI (protected health information) in order to inspect and/or obtain copies
- ❑ Right to amend PHI
- ❑ Right to accounting of disclosures over past 6 year period

# HIPAA ISSUES

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- ❑ Confidentiality of client PHI assured through secure transmissions (email secure or fax).
- ❑ Program must determine the identity and authority of person requesting PHI before it is released

# HIPAA ISSUES

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- ❑ **DOCUMENTATION OF RELEASES**
- ❑ When entity releases information to:
  - ❑ EMT in medical emergency
  - ❑ Police in case of crime on premises
  - ❑ Child abuse/neglect report
  - ❑ Prevent harm
  - ❑ Court Order
- ❑ **ALL MUST BE DOCUMENTED IN CHART!**

# General Rule of Disclosure

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- Treatment Programs may only release information or records that will directly or indirectly identify a client as a substance abuser or treatment patient:
  - With a knowing and written consent from the participant, AND
  - Other exceptions (explained earlier)

# CONSENT

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- ❑ A proper consent can authorize all parties involved in the drug court to share information necessary to monitor treatment progress and compliance.
- ❑ To be effective the consent form should be signed at in-take.

# PRACTICAL SAFEGUARDS

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- ❑ Do not leave papers containing PHI lying around where others can see them
- ❑ At end of workday – clear desk or other exposed areas of PHI and place in secure location (file, cabinet, desk drawer).
- ❑ Do not talk about patient PHI in public areas
- ❑ If you take work home don't leave it in a place accessible to people not agency employees, keep locked in a briefcase or in car/trunk.



# HIPAA vs. 42 CFR Part 2



# HIPAA vs. 42 CFR Part 2 (1)

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- ❑ The laws cover a lot of the same material.
- ❑ Some points of difference – more specific or more recent rule usually applies.
- ❑ For the CD Treatment providers, in most cases the rules of 42 CFR Part 2 are more stringent
- ❑ In some cases HIPAA wins.

# HIPAA vs. 42 CFR Part 2 (2)

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- Many HIPAA provisions PERMIT something but don't mandate it.
- 42 CFR Part 2 PROHIBITS all disclosures unless specifically allowed by the regulation.

# Disclosure for Payment

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- ❑ HIPAA PERMITS disclosure with out patient consent for the purpose of payments.
- ❑ 42 CFR Part 2 PROHIBITS these disclosures with out patient consent.

SUD/AOD providers must follow 42 CFR Part 2.

# Patient Rights & Administrative Requirements

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- HIPAA imposes several new administrative requirements and establishes new patient rights.
- These are not included in 42 CFR Part 2.

SUD/AOD providers must follow HIPAA.

# Re-disclosure of Information

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- HIPAA is silent on this topic.
- 42 CFR Part 2 requires that a statement prohibiting re-disclosure accompanies the patient information that is disclosed.

SUD/AOD providers must follow 42 CFR Part 2.

# Disclosures to Other Providers

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- ❑ HIPAA allows, but does not require, programs to make disclosures to other healthcare providers without authorization.
- ❑ 42 CFR Part 2 limits this to medical emergencies.

SUD/AOD providers must follow 42 CFR Part 2.

# Medical Emergencies

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- HIPAA allows health care providers to inform family members of the individual's location and condition without consent in emergency circumstances or if a person is incapacitated.
- 42 CFR Part 2 limits this disclosure to medical personnel ONLY.

SUD/AOD providers must follow 42 CFR Part 2.



# Disclosure to Public Health

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- ❑ HIPAA permits disclosure to a public health authority for disease prevention or control, or to a person who may have been exposed to or at risk of spreading a disease or condition.
- ❑ 42 CFR Part 2 prohibits these disclosures unless there is an authorization, court order, or the disclosure is done with out revealing patient information.

SUD/AOD providers must follow 42 CFR Part 2; some state laws compel notification.

# Right to Access Records

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- ❑ HIPAA REQUIRES a covered program to give an individual access to his/her own health information (with few exceptions).
- ❑ 42 CFR Part 2 gives programs DISCRETION to decide whether to permit patients to view or obtain copies of their records, unless they are governed by a state law that gives right to access.

SUD/AOD providers must follow HIPAA.

# New Issues in Confidentiality

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□ Oh Noooooo....

What do I do?



# ACTIVITY:

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- ❑ **What confidentiality and privacy concerns have you been faced with at your sites?**
- ❑ **In a group of 3-4, develop a case or example where confidentiality issues have arisen.**
- ❑ **Prepare to present the case and give feedback on other cases.**

# Handling Difficult Patients and Crises



# ACTIVITY

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- Form groups of 4-6.
- Discuss 2 examples of crises faced by your staff
- What made these crises challenging to deal with?

# Things to Consider When Facing a Crisis

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# Things to Consider...

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- Are *you* safe?
  - Are *other* clients safe?
  - Is the *client in crisis* safe?
  - Can *I* handle this?
  - What *other resources* do I need?
  - How do I *feel better* after it's over?



# Are you safe?

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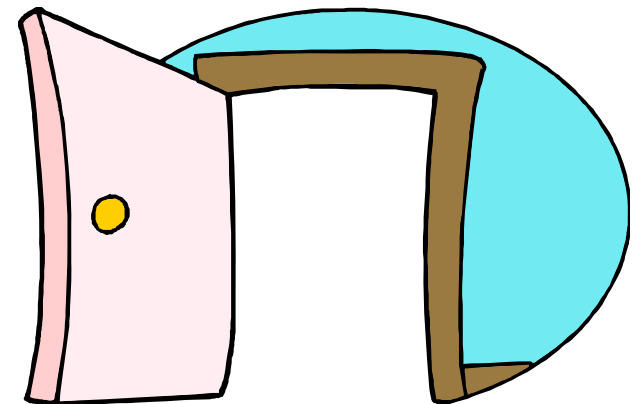
Protecting your safety is protecting the safety of the client

- If they hurt you
  - They will no longer feel safe,
  - They will no longer be able to receive treatment from your agency
- Putting your safety first is in the best interest of the client.

# Keeping yourself safe...

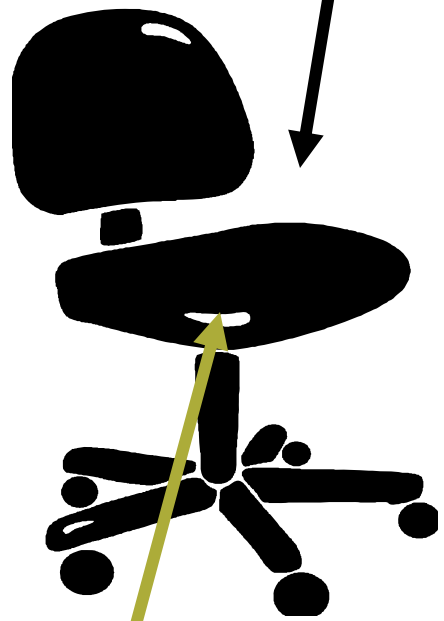
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- The Office Setup
  - Be conscious of where you are in the office

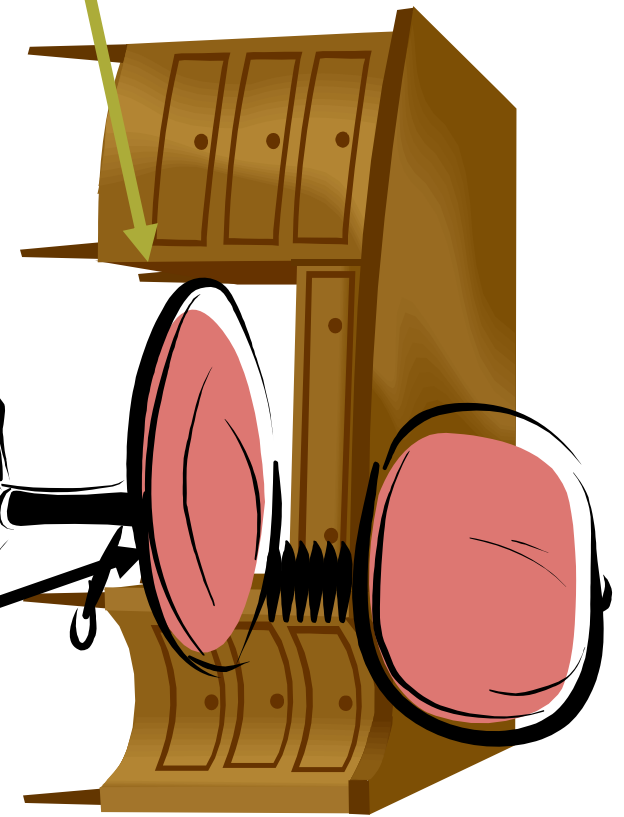


Client

Counselor



Counselor



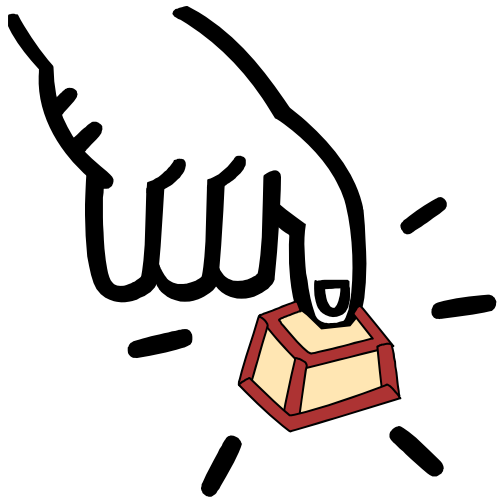
Client



# Keeping yourself safe...

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- The Office Setup
  - Be conscious of where you are in the office
  - Be aware of ways of asking for help

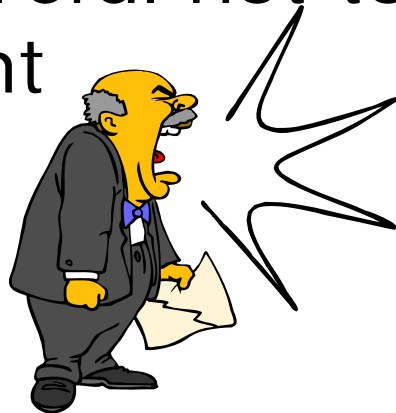


# Keeping yourself safe...

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## ■ Personal Style

- Be careful not to reflect negative emotional states
- Watch your body language
- Stay calm and keep your voice tone low and soft
- Be careful not to stand over or lean into patient



# Keeping yourself safe...

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- If none of that works...
  - Get out
    - Take a break
    - Leave the office
    - Leave the building
  - Get help
    - Call a supervisor
    - Call a colleague
    - Call the police





# Things to Consider...

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- Are **you** safe?
- ▶ Are **other** clients safe?
  - Is the **client in crisis** safe?
  - Can **I** handle this?
  - What **other resources** do I need?
  - How do I **feel better** after it's over?

# Are other clients safe?



Where is the crisis happening?

- If other clients are observing, they may not feel safe

- We do not want to contribute to the chaos of their lives

- They want to have confidence in their environment.

- A crisis with one client may lead to a crisis with another



# Keeping other clients safe...

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- Remove the situation to a quiet, safe place. This will help to:
  - Calm the participant (and you)
  - Protect confidentiality
  - Protect other clients from direct harm
  - Protect other clients from “helping”





# Things to Consider...

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- Are **you** safe?
- Are **other** clients safe?
- Is the **client in crisis** safe?
- Can **I** handle this?
- What **other resources** do I need?
- How do I **feel better** after it's over?

# Is the client in crisis safe?

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Is the Client a danger to:

- Self?
- Others?

If danger = being aggressive, follow recommendations above

If danger = killing self or others, follow recommendations above AND make sure they get assessed.

# What is a Suicide/Homicide Assessment?

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- If you think that someone wants to kill him/herself or someone else, they must be evaluated.
  - If risk is significant, they may need to be hospitalized.
  - If risk is minimal, a plan needs to be developed in case feelings get worse.

# Substance Use as a Risk factor

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- Suicide is leading cause of death among substance abusers.
- Individuals treated for SUD are at 10x greater risk for suicide; 14x for IDU.
- Co-occurring depression is associated with *both* SU and suicidal behavior.
- People with SUD often seek treatment when they are most vulnerable and when their SU symptoms are most severe.

# Mental Illness as a Risk factor

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- Common psychiatric risk factor leading to suicide
  - Depression\*
  - Major Depression
  - Bipolar Depression
  - Schizophrenia
- Other psychiatric risk factors with potential to result in suicide
  - Post Traumatic Stress Disorder (PTSD)
  - Eating disorders

## Other Risk factors

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- ❑ Major physical illness-especially recent
- ❑ Chronic physical pain
- ❑ History of trauma, abuse, or being bullied
- ❑ Family history of death by suicide
- ❑ Being a smoker
- ❑ Aggressive or impulsive personality

## Facing the facts...

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### **Suicide Communications Are Often Not Made to Professionals**

- ❑ Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.
- ❑ In one psychological autopsy study only 18% told professionals of intentions.
- ❑ In a study of suicidal deaths in hospitals:
  - 77% denied intent on last communication
  - 28% had “no suicide contracts” with their caregivers



# Points to Keep You on Track

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- ❑ Suicidal clients are ambivalent about living/dying (hesitation wounds).
- ❑ Suicidal crisis is a transient state, and can be overcome.
- ❑ Suicide assessment is a vital clinical tool.
- ❑ Prevention actions should extend beyond immediate crisis.
- ❑ Use contracts cautiously/sparingly.
- ❑ Risk may persist even after becoming clean/sober.
- ❑ All attempts must be taken seriously.
- ❑ Generally, warning signs exist.
- ❑ Ask directly about suicide.

# Protective Factors

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Buffers that lower long-term risk:

- ❑ Reasons for living
- ❑ Being clean and sober; 12-step participation
- ❑ Religious or spiritual teaching oppose suicide
- ❑ Presence of a child in the home
- ❑ Intact marriage
- ❑ Trusting relationship with service provider
- ❑ Employment

# ACTIVITY

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**In a small group, generate a list of any/all warning signs of suicidal thoughts/behaviors.**

# Symptoms and Warning Signs of Suicide

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## **Danger**

- ❑ Talking about suicide.
- ❑ Statements about hopelessness, helplessness, or worthlessness.
- ❑ Preoccupation with death.
- ❑ Suddenly happier, calmer.
- ❑ Loss of interest in things one cares about.
- ❑ Visiting or calling people one cares about.
- ❑ Making arrangements; setting one's affairs in order.
- ❑ Giving things away, such as prized possessions.

# Symptoms and Danger Signs

## Warning Signs of Suicide

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### Warning Signs

- ❑ **Observable signs of serious depression**
  - Unrelenting low mood
  - Hopelessness
  - Anxiety
  - Withdrawal
  - Sleep problems
- ❑ **Increased alcohol and/or other drug use**
- ❑ **Recent impulsiveness and taking unnecessary risks**
- ❑ **Threatening suicide or expressing strong wish to die**
- ❑ **Making a plan** (giving away possessions, obtaining other means of killing oneself)
  - **Unexpected rage or anger**

# Quick Suicide Screen

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- ❑ Have you ever wanted to go sleep and not to wake up?
- ❑ Have you ever thought about hurting or killing yourself?
- ❑ If you were to kill/hurt yourself, how would you do it?
- ❑ If above is yes, have you carried any of that plan out?

# Quick Suicide Screen

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- Do you ever feel so badly that you think about suicide?
- Do you have a plan to commit suicide or take your life?
- Have you thought about when you would do it (today, tomorrow, next week)?
- Have you thought about what method you would use?

# Quick Suicide Screen: SLAP the Client

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## Assessing Suicidal/Homicidal Ideation (SLAP)

S—Severity of the ideation

L—Lethality of chosen means

A—Access to chosen means

P—Proximity of support

## Certificate of Confidentiality DOES NOT PROTECT

- child/elder abuse
- communicable diseases, state-specific
- danger to self or others



# ACTIVITY

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**In a group of 3-4, review the below clinical case. As Rob's counselors:**

- **What are the risk factors?**
- **Protective factors?**
- **What more do you want to know?**
- **How do you address Rob?**
- **How do you handle the group's anxiety?**

# Meet Rob

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- 39-year-old male; gay-identified, long-term partner is threatening separation.
- Has been a victim of abuse and bullying in his youth.
- History of experimentation beginning in early teens and through 20's; heavy alcohol use for past 6 years.
- First treatment episode - IOP program for alcohol abuse.
- Employed; EAP identified depression and heavy alcohol use, and referred him to tx.
- Nearing completion of 4 month program.
- During group, Rob stated, "I might be better off dead."
- Group members immediately question Rob about comment and suicidal thoughts, which he denies.
- Group members seem concerned about comment; Rob minimizes - saying he "might have over-reacted."

# Myths versus facts...

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## □ **MYTH:**

People who talk about suicide don't complete suicide.

## □ **FACT:**

Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

## Myths versus facts...

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- **MYTH:**

Suicidal people are fully intent on dying.

- **FACT:**

Most suicidal people are undecided about living or dying – which is called suicidal ambivalence. A part of them wants to live, however, death seems like the only way out of their pain and suffering. They may allow themselves to “gamble with death,” leaving it up to others to save them.

## Myths versus facts...

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### □ **MYTH:**

Males are more likely to be suicidal.

### □ **FACT:**

Men COMPLETE suicide more often than women. However, women attempt suicide three times more often than men.

# Myths versus facts...

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## □ **MYTH:**

Asking a depressed person about suicide will push him/her to complete suicide.

## □ **FACT:**

Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

## Myths versus facts...

---

### □ **MYTH:**

Improvement following a suicide attempt or crisis means that the risk is over.

### □ **FACT:**

Most suicides occur within days or weeks of “improvement” when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.

# ACTIVITY

---

**In a group of 3-4, review the below clinical case. As Angela's counselors:**

- What more do you want to know? What are your concerns?
- What are her risks for relapse an/or suicide?
- What are Angela's risk factors? Protective factors?
- What do you need to take into account as you prepare to discharge her?



# Meet Angela

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- 44-year-old female; history of bipolar disorder and substance use.
- Unstable employment, housing and medication adherence; living with brother, sister-in-law and their 2 children.
- Medical detox twice in past 4 years; adult children – no contact.
- Currently in residential tx. that focuses on her COD, following relapse to crack cocaine and a suicide attempt.
- Suicide attempt was an overdose of prescription meds., following a cocaine binge lasting several weeks.
- Ct. has responded well to treatment and denies any current suicidal thoughts.
- She shows poor insight into the severity of her MI and DU.
- Ct. is discharging soon; brother and family expressed discomfort with her returning to family home. Tx. team needs to develop discharge plan and resources.

# Intervention

---

## **If You See the Warning Signs of Suicide...**

- **Begin a dialogue;**
  - Suicidal thoughts are common with depressive illnesses
  - Your willingness to talk about it in a non-judgmental, non-confrontational way help a person accept professional help.

# Intervention

---

- **Four Basic Steps**
  1. **Show you care**
  2. **Be genuine**
  3. **Ask about suicide**
  4. **Get help**

# Show You Care and Be Genuine

---

- **Let the person know you really care. Talk about your feelings and ask about his or hers.**
  - "I'm concerned about you...about how you feel."
  - "You mean a lot to me and I want to help."
  - "I care about you, about how you're holding up."
  - "I don't want you to kill yourself."
- **Take ALL talk of suicide seriously**
  - If you are concerned that someone may take their life, trust your judgment!

# Ask About Suicide

---

## **Be direct but non-confrontational**

- **Don't hesitate to raise the subject.**
  - Talking with people about suicide won't put the idea in their heads.
  - If you've observed warning signs, they're already thinking about it.
  - Be direct in a caring, non-confrontational way.
  - Get the conversation started.

## Ask About Suicide

---

- Treatment – Extending Action
  - Do you have a therapist/doctor?
  - Are you seeing him/her?
  - Are you taking your medications?



## Things to Consider...

---

- Are **you** safe?
- Are **other** clients safe?
- Is the **client in crisis** safe?
- Can **I** handle this?
  - What **other resources** do I need?
  - How do I **feel better** after it's over?

# Can I handle this?

---



- Do I have the skills to handle this situation alone?
  - Do I have the training?
  - Do I feel confident enough?
- Recognizing your limitations is a **strength**, not a weakness
  - Know **when** to ask for help.
  - Know **where** to ask for help.





## Get help

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...But do NOT leave the person alone

- Know referral resources
- Reassure the person
- Encourage the person to participate in helping process
- Outline safety plan



## Things to Consider...

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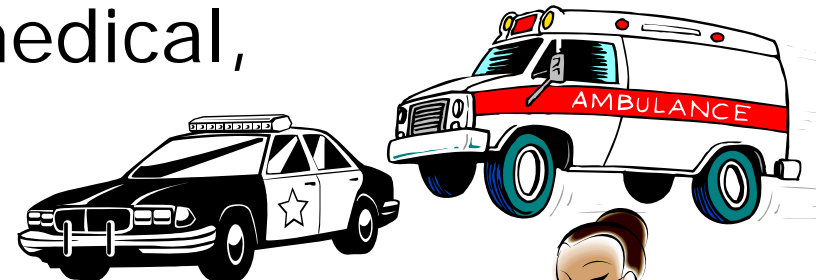
- Are **you** safe?
- Are **other** clients safe?
- Is the **client in crisis** safe?
- Can **I** handle this?
- What **other resources** do I need?
- How do I **feel better** after it's over?

# What other resources do I need?



## Immediate assistance

- Another person to help with the crisis
- Other staff to take care of the rest of the clients
- Emergency personnel (medical, psychiatric, legal)



## Ongoing assistance

- Capitalize on the learning opportunity
- Remember crises get easier with practice





## Things to Consider...

---

- Are **you** safe?
- Are **other** clients safe?
- Is the **client in crisis** safe?
- Can **I** handle this?
- What **other resources** do I need?
- How do I **feel better** after it's over?

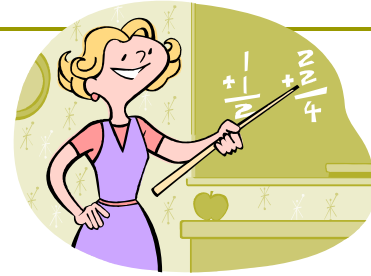
# How do I feel better after a client crisis is over?

---


- Talking about the situation is essential
  - Supervisor
  - Colleagues
- Determining what went well and what you could do better in the future will improve skill and confidence
- Burnout occurs if you don't find ways of leaving it at work...this is a skill

# New Things In Confidentiality & Ethics for Addiction Counselors

## Objectives:



- 1. Gain basic understanding of how electronic health information is **exchanged**
- 2. Understand **consent** requirements for the electronic exchange of health information pertaining to alcohol/drug treatment
- 3. Generally **raise awareness** of new guidelines and practices under ACA. Do your own homework. Consult your agency leadership.



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Health Information Exchange,  
Health Information Organizations

# HOW DOES HIT WORK?

# What is HIT?

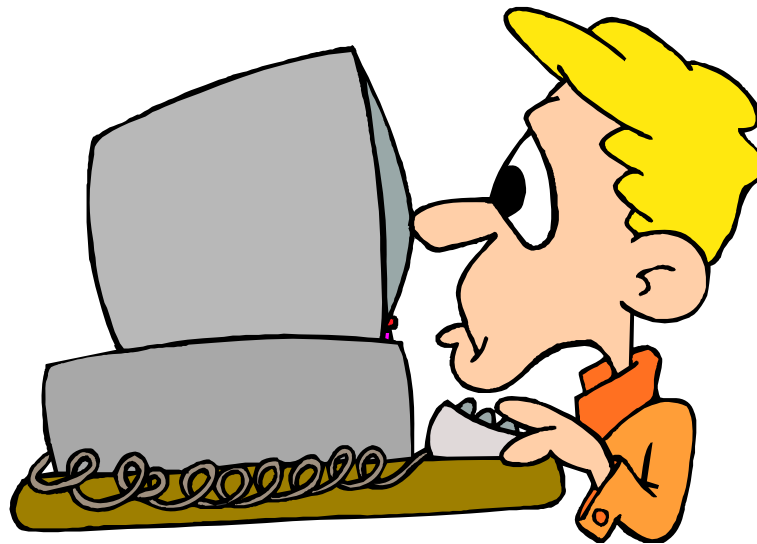
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**“HIT”** (Health Information Technology) = the use of computers and computer programs to store, protect, retrieve, and transfer clinical, administrative, and financial information electronically within health care settings.



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# HIT presents unique challenges for alcohol/drug treatment programs



# How does HIT work?

---

- ❑ To understand why HIT presents special confidentiality challenges for alcohol/drug treatment programs (Part 2 programs), a very **basic** understanding of how HIT works (**structure**) is needed
- ❑ Here is a simplified overview of Health Information Exchange (**HIE**) and Health Information Organizations (**HIOs**)

# How does HIT work?

---

▶ **Health Information Exchange (HIE) =**

various methods and mechanisms through which information can be exchanged electronically via a computer network between/among health care providers and other health care stakeholders

▣ **Health Information Organizations (HIOs) =**

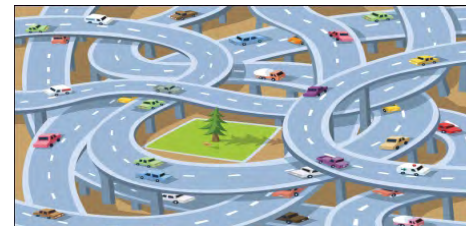
an organization that oversees and governs the exchange of health-related information among organizations

# How does HIT work?

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## What do these definitions really mean?

- ❑ An **HIE** is essentially a system that enables people to exchange health information electronically
- ❑ An **HIO** is basically an organization/network that sets up rules of the road for that electronic exchange of health information



# What do you need to know about HIE and HIOs?

---

- ❑ HIE is commonly facilitated by a HIO
- ❑ HIOs can be structured in many different ways
- ❑ HIO-affiliated members generally put information into and/or take information out of the HIO's electronic network

# What do you need to know about HIE and HIOs?

---

## What is a HIO-affiliated member?

- ▶ **HIO-affiliated members** = entities that participate in the HIO network
  
- ▶ Examples of HIO-affiliated members:
  - Health care providers (including alcohol/drug treatment programs)
  - Insurance companies
  - Labs
  - Pharmacies



# What do you need to know about HIE and HIOs?

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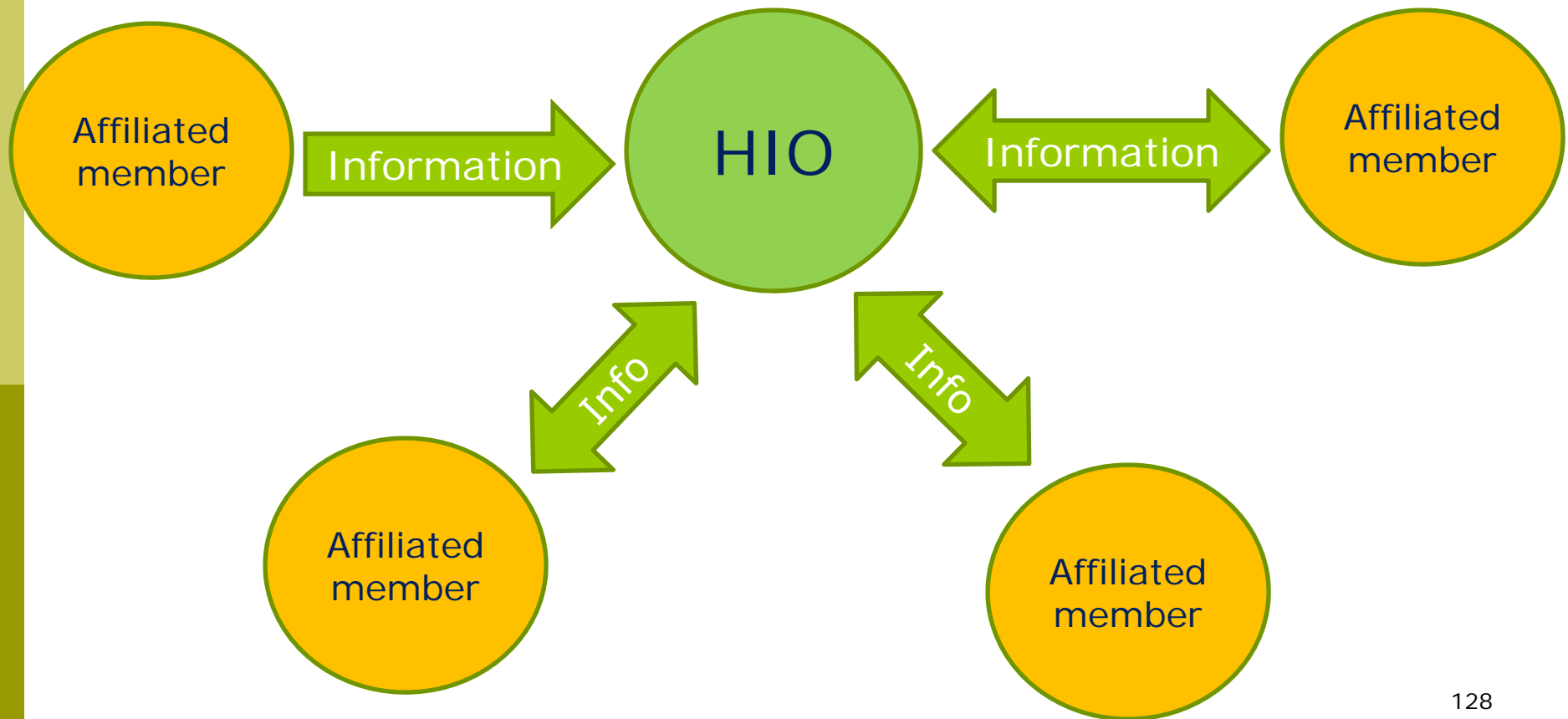
## How are HIOs Structured?

- ▶ **Examples** of ways that HIOs can be structured:
  - A HIO can **hold** information in a **central repository**, which affiliated members put information into and take information out of
  - Affiliated members can **retain** their own information, and the HIO can make **queries** between affiliated members
- ▶ Regardless of how a HIO is structured, it is almost always an **intermediary** that moves information between affiliated members

# What do you need to know about HIE and HIOs?

---

Here is an example of a classic HIO:





# What do you need to know about HIE and HIOs?

---

- The **flow** of health **information** from HIO-affiliated members to HIOs to other HIO-affiliated members is where federal alcohol/drug **confidentiality** law (42 C.F.R. Part 2) becomes involved



129

# 42 C.F.R. Part 2 & HIO Structure

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**RULE: 42 C.F.R. Part 2 applies  
no matter how a HIO is  
structured!**



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Patient Choice Models

# **HOW DOES HIT WORK?**

## **(CONTINUED)**

# How does patient information get into HIE/HIOs?

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- ❑ The level of **control** an individual has over whether and how his/her health information is **included in** and **exchanged through** an HIE varies based on the **patient choice model** in place
- ❑ **Patient Choice Models**= whether, to what extent, and how individuals have the ability to control the electronic exchange of their health information

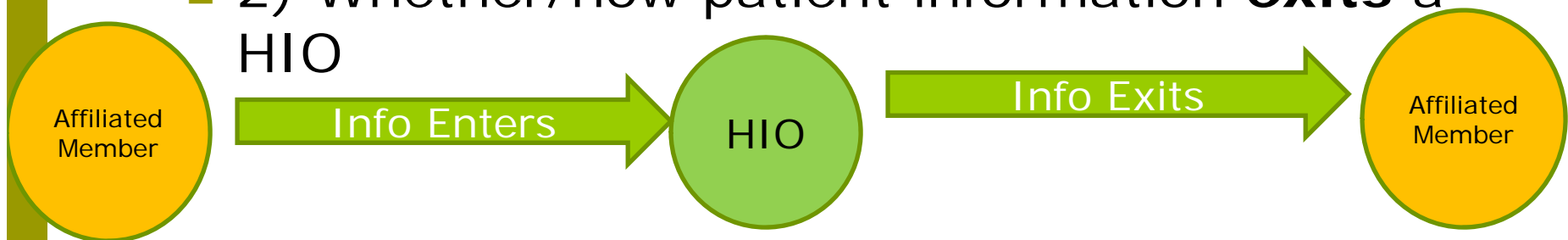


# How does patient information get into and flow through HIE/HIOs?

---

□ **Note** that **patient choice models** affect **two** discrete functions:

- 1) Whether/how patient information **enters** a HIO
- 2) Whether/how patient information **exits** a HIO



# How does patient information get into and flow through HIE/HIOs?

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## Types of **Choice Models**:

- ▶ (1) No Consent
- ▶ (2) Opt-Out
  - Opt-Out with Exceptions
- ▶ (3) Opt-In
  - Opt-in with Restrictions

## Part 2 Programs & Choice Models

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- For alcohol/drug treatment programs (**Part 2 programs**), understanding the program's obligations under the various **choice models** is more **complicated** than for other HIO-affiliated members



## 42 C.F.R. Part 2 & Choice Models

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Part 2 programs **must comply** with the requirements of 42 C.F.R. Part 2 no matter what **type of choice model** is in place.



# How does patient information get into and flow through HIE/HIOs?

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## Choice Model #1:

- (1) **No Consent:** patients' health information is automatically included in the exchange, without their consent (patients cannot opt out of participating in the exchange)

# Why are choice models more complicated for Part 2 programs?

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## No Consent model:

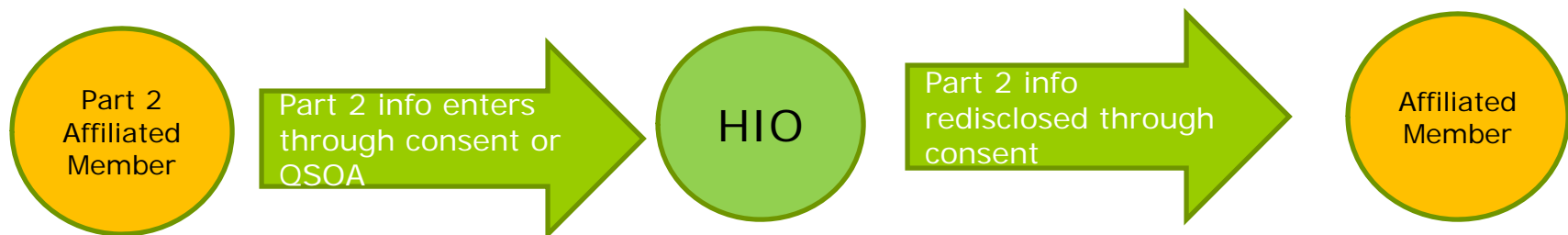
- ▶ While this model says HIO-affiliated members can include patients' information in the exchange without obtaining patients' consent...
- ▶ Under Part 2, information can only be made available to a HIO for electronic exchange if a patient signs a consent or a QSOA is in place (QSOAs will be discussed in Webinar 3). And patient consent is needed before a HIO can redisclose the Part 2 information.

more...

# Why are choice models more complicated for Part 2 programs?

## No Consent model (cont.):

- Therefore, **even if** the model in place requires no consent, the Part 2 program **must follow** 42 C.F.R. Part 2's requirements and obtain consent or use a QSOA to make information available to the HIO for electronic exchange, and consent to authorize the HIO to redisclose this information. (Consent and redisclosure requirements will be discussed shortly.)



# How does patient information get into and flow through HIE/HIOs?

---

## Choice Model #2

- (2) **Opt-Out**: patients' health information is automatically **included** in the exchange, **unless** a patient opts out **completely**
  - **Opt-Out with Exceptions**: patients' health information is automatically **included** in the exchange, **but** the patient can opt out completely **or** allow only certain information to be included

# Why are choice models more complicated for Part 2 programs?

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## Opt-Out model

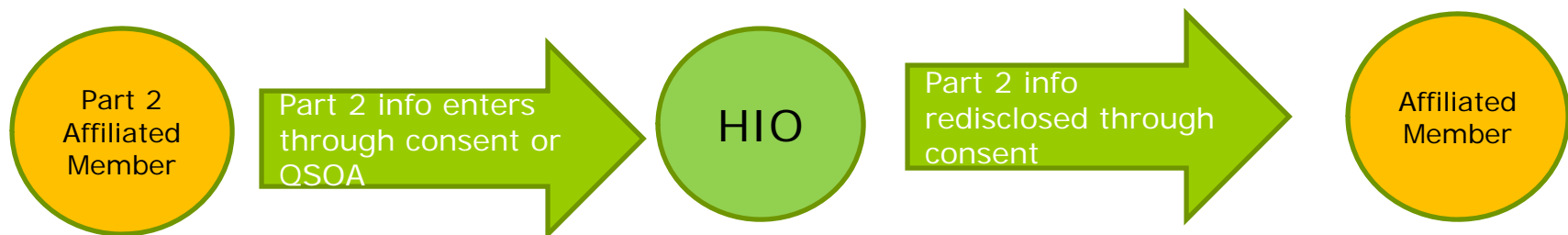
- ▶ While this model says HIO-affiliated members can include patients' information in the exchange without consent unless patients opt out...
- ▶ As we just noted, under Part 2, information can only be made available to a HIO for electronic exchange if a patient signs a consent or a QSOA is in place (QSOAs will be discussed in Webinar 3). And patient consent is needed before a HIO can redisclose the Part 2 information.

More...

# Why are choice models more complicated for Part 2 programs?

## Opt-out model (cont.):

- Therefore, as with the no consent model, the Part 2 program **must follow** 42 C.F.R. Part 2's requirements and obtain consent or use a QSOA to make information available to the HIO for electronic exchange, and consent to authorize the HIO to redisclose this information. (Consent and redisclosure requirements will be discussed shortly.)



# How does patient information get into and flow through HIE/HIOs?

---

## Choice Model #3

- (3) **Opt-In**: patients' health information is **not included** in the exchange, **unless** a patient actively expresses **consent** to be included, in which case **all** of the patient's health information is included
  - **Opt-In with Restrictions**: patients' health information is automatically **not included** in the exchange, **but** the patient may allow certain information to be included

# Why are choice models more complicated for Part 2 programs?

---

## Opt-In model:

- ▶ Since this **model** says HIO-affiliated members can only include patients' information in the exchange with their **consent**...
- ▶ Even though Part 2 authorizes programs to **enter** patients' information into the exchange with just a QSOA, this is not allowed in an opt-in model, as Part 2 programs must follow the HIO's **stricter requirements** that provide more privacy protection...

more...



# Why are choice models more complicated for Part 2 programs?

## Opt-in model (cont.):

- Therefore, the Part 2 program **must** obtain **consent** to enter patient information into the HIO, pursuant to the opt-in choice model, and using Part 2's other option, QSOA, would not be permitted.



# Choice Model



## Case scenario/Poll

- Jessica is a patient in ABC, a Part 2 Program. ABC participates in an exchange that uses a no consent patient choice model (i.e., patient records are automatically included in the exchange, and redisclosed to other members without first obtaining patient consent). ABC can:

more...

# Choice Model

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## Case scenario/Poll (cont):

### Possible answers:

- 1) *Include* Jessica's records in the exchange without first obtaining her consent, because a no consent model does not require patient consent.
- 2) *Not include* Jessica's records in the exchange unless Jessica signs a consent form authorizing the Part 2 program to disclose her records to the HIO or a QSOA is in place, and Jessica signs a consent form allowing the HIO to redisclose her Part 2 records.

# Case Scenario/Poll – Answer:

---

Correct answer:

- 2) *Not include*** Jessica's records in the exchange unless Jessica signs a consent form authorizing the Part 2 program to disclose her records to the HIO or a QSOA is in place, and Jessica signs a consent form allowing the HIO to redisclose her Part 2 records.

# HAVE QUESTIONS?

**Now for your  
questions...**






---

# Consent Issues related to HIE

1. Overview of Consent
2. Elements a consent form must contain
3. Uses of consent forms
4. Redisclosure
5. Issues relating to minors



---

What is required to  
disclose Part 2  
information to and  
through a HIO?

# 1. OVERVIEW OF CONSENT

# 42 C.F.R. Part 2: General Rule

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As stated in earlier slide

- ▶ A **program** covered by Part 2 –
  - may not **disclose** information
  - that **identifies** a **patient** as having a current or past **drug/alcohol** problem or as a participant in a Part 2 program
  - unless the patient **consents** in writing or another **exception** applies.



# Overview of Consent

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- ▶ Part 2 permits a Part 2 program to disclose patient identifying information to a HIO

Only with a:

- Part 2 compliant consent form OR
- QSOA agreement between the program and the HIO (QSOAs will be discussed in Webinar #3.)

# Overview of Consent

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## Consent


- ❑ Primary tool for enabling information to flow
- ❑ Adaptable to many situations
- ❑ Most disclosures are permissible if a patient signs a valid consent form

# Overview of Consent

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As stated in Webinar #1, key requirements for Part 2 compliant consent:

- Proper form – all required elements
- Redisclosure notice required
- Permits disclosure, but does not require it
- HIPAA only:
  - may not condition treatment on signing consent
  - copies given to patient



---

What are the required elements a Part 2 consent form must contain for information to flow to and through a HIO?

## **2. ELEMENTS OF CONSENT FORMS**

# Elements of Consent Forms

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Part 2 consent form must be in writing (no oral consent) and contain:

1. name or general designation of program(s) permitted to make the disclosure;
2. name or title of individual(s) or name of organization(s) permitted to receive the disclosure (recipient)
3. name of patient whose information is being disclosed

more...

# Elements of Consent Forms

---

## **Proper Part 2 consent form (cont.)**

4. purpose of disclosure;
5. how much and what kind of information to be disclosed;
6. signature of patient and/or other authorized person (will discuss minors later in presentation); and

more...

# Elements of Consent Forms

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## **Proper Part 2 consent form (cont.):**

7. date consent is signed;
8. statement of patient's right to revoke the consent at any time except if program relied on it;
9. date, event or condition upon which the consent will expire if not previously revoked – no longer than necessary to serve stated purpose;

# Elements of Consent Forms

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## Proper Part 2 form (cont.):

### HIPAA's additional requirements:

1. program's ability to condition treatment, payment, enrollment or eligibility of benefits on patient signing the consent, by stating that the program may not condition these services on consent, *or* the consequences for refusal to consent;
2. Plain English.

Sample consent forms on LAC's website:

[www.lac.org/index.php/lac/alcohol\\_drug\\_publication](http://www.lac.org/index.php/lac/alcohol_drug_publication)  
S



# Elements of Consent Forms

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Several of the items that must be included in a consent form merit further explanation.



We will now discuss those elements in more detail.

# Consent Forms: Disclosing Party

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- ▶ Consent form must identify the party ***making the disclosure.***
- Consent can identify party:
  - by name OR
  - by general designation.

more...

# Consent Forms: Disclosing Party

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For example, the form could identify the disclosing party by ***name*** as:

- ABC treatment program

more...

# Consent Forms: Disclosing Party

---

- OR for example, the form could use a ***general designation*** to identify the disclosing party, such as:
  - All programs in which the patient has been enrolled as an alcohol or drug abuse patient. See XYZ HIO website for list of affiliated programs.

# Consent Forms: Recipient

---

Consent form must identify the party *receiving* the Part 2 information.

- Consent can identify recipient only by:
  - Name of organization OR
  - Name or title of individual.
- A consent form cannot identify the recipient by general designation.
- ▶ Stricter requirements for recipient than for disclosing party.

# Consent Forms: Recipient

---

## Case scenario / poll

- ❑ Can a Part 2 compliant consent form identify the recipient of information as “all members of XYZ HIO, see website for complete list”?

# Consent Forms: Recipient

---

Possible answers:

1. Yes because the website will have a complete list of programs that may receive Part 2 information.
2. No because reference to a list on a website is not sufficient for identifying recipients of Part 2 information.

# Consent Forms: Recipient

---

- ❑ No. Consent form MUST list all authorized ***recipients*** of Part 2 information by name or title of the individual or name of the organization.
  - Attaching a list of names of recipients to the consent IS sufficient.
  - Referring to a list on a website is NOT sufficient.
  - Because Part 2 consents must list recipients by name, they may NOT include future programs that join a HIO after the consent was signed.



## Consent Forms: Purpose and Extent

---

- ▶ Consent form must state the purpose for which information can be disclosed AND
- ▶ How much and what kind of information is to be disclosed.
  - Consent form must limit the amount of information to be disclosed to the minimum amount necessary to accomplish the purpose.

## Consent Forms: Purpose and Extent

---

- In order to ensure that the consent form limits the amount of information to be disclosed to the minimum amount necessary to accomplish the purpose,
  - ▣ the purpose or need for the communication of information should be considered first, and then that can be used to determine how much information will be disclosed.

# Consent Forms: Purpose and Extent

## Purpose and Extent (cont.)

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- ▶ For example,
  - If the purpose of the disclosure is payment, the amount of information could be limited to dates of attendance and diagnosis, if needed. Usually the release of the entire record is not necessary for reimbursement.
  - If the purpose of the disclosure is treatment, the Part 2 program can use discretion to determine how much information to include and can permit release of entire record if necessary.

# Consent Forms: Expiration

➤ Consent must specify the:

---

- date or
- event or
- condition



upon which the consent will expire if not revoked before.

more...

# Consent Forms: Expiration

---

## **Expiration** (cont.)

- It is NOT permissible for consent to say effective “until consent is revoked.”
  - Date, event or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.
    - But, Part 2 allows consent to remain in effect a long time if necessary.

# Consent Forms: Expiration

---

## Case Scenario / Poll

- ❑ Can a consent specify a consent as expiring “upon my death”?

# Consent Forms: Expiration

---

Possible answers:

- ❑ 1. No, because an expiration date or event must occur within 1 year of signature.
  
- ❑ 2. Yes, if the purpose of the consent justifies its remaining in effect until the person's death.

# Consent Forms: Revocation

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Correct answer:

2. Yes. Consents may remain in effect only as long as necessary, but a lifetime may be appropriate for consent to release to a HIO.
- 42 CFR 2 does not set any particular time limit on how long a consent can remain in effect, BUT state law or policy may. So in some states, such a long period would not be permissible.



# Consent Forms: Revocation

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Consents should contain a statement that the consent is revocable at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

more...

# Consent Forms: Revocation

---

- If a patient revokes consent,
  - Disclosing program or person should:
    - note revocation in patient's record, AND
    - clearly communicate the revocation to the HIO.
  - HIO should have policies and procedures in place for implementing patient decisions to give and revoke consent.

more...

Prepared by the Legal Action Center with support  
from Partners for Recovery Initiative and SAMHSA

# Consent Forms: Revocation

→ If a patient revokes consent,

---

- The HIO must be able to implement the revocation decision and no longer transmit the Part 2 program's protected patient information to the entity for which consent has been revoked.
- While consent can be revoked orally under Part 2, SAMHSA recommends that the entity obtaining the revocation get it in writing and/or document it in the patient's record.

more...

# Consent Forms: Revocation

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- ▶ Revocation (cont.)
- ▶ A single consent form can allow for disclosures to multiple parties.
- ▶ If multiple parties are listed on a consent form, a patient can revoke consent with regard to one party while leaving the rest of the consent in force.

(Multiple party consents will be discussed shortly.)

# Consent Forms: Signature

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8. A signature is always required on a Part 2 consent.

- But, an **original** (“wet”) consent is not required.



- Electronic signatures are valid IF
  - Consent recipient acts with reasonable caution to verify authenticity of signature AND
  - An electronic signature is valid under applicable law.

# HAVE QUESTIONS?

---

**Now for your  
questions...**





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# 3. USES OF CONSENT FORMS

# Uses of Consent Forms

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Some particular issues arise when using consent forms in the HIE context that we will now discuss.

- ▶ Using Part 2 consent forms:
  1. For multiple disclosures
  2. For multiple parties
  3. For multiple purposes
  4. After a Part 2 program has merged or restructured
  5. For release of information to unnamed on call providers.



# Uses of Consent Forms

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## Multiple disclosures

- Information may be disclosed multiple times without new consents as long as:
  - consent has not expired or been revoked, and
  - the entities receiving the information, the nature of the information, and the purpose for disclosure remain the same.

# Uses of Consent Forms

---

- The same Part 2 consent form can authorize disclosure to a HIO and redisclosure by a HIO to other HIO affiliated providers IF:
  - the purpose for the disclosure is the same and
  - the required statement prohibiting redisclosure accompanies the information so that each subsequent recipient of the information is notified of the prohibition on redisclosure. (Notice prohibiting redisclosure will be discussed shortly.)

# Uses of Consent Forms

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## **Multiple Parties**

- ▶ Part 2 allows use of multi-party consent forms authorizing the exchange of information between multiple parties named in the consent form as long as the form makes clear:
  - that the parties may disclose to each other and
  - The stated purposes for which information may be disclosed.

more...

FAQ I(14)  
187

# Uses of Consent Forms

## Multiple Purposes

- ▶ Part 2 allows use of a single consent form authorizing disclosure of Part 2 information to different recipients for different purposes as long as the form makes clear:
  - What information may be given to which recipients; and
  - for which purposes.

more...

FAQ I(14)  
188

# Uses of Consent Forms

---

## Multiple Purposes (cont.)

- ❑ Part 2 requires a consent form to specify the kind and amount of information that is to be disclosed to each recipient.
- ❑ The consent form must limit different recipients' access to only the kind and amount of patient information needed to fulfill the purpose for which they are allowed access.

more...

FAQ II(4)  
189

# Uses of Consent Forms

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## Poll / Scenario

A Part 2 consent form lists recipients as “HIO affiliated health care providers” and “payors.” The purpose for the disclosure to the HIO affiliated health care providers is “treatment”, and purpose for the disclosure to payors, “payment for treatment rendered.” The information listed to be disclosed is the entire record. Does this comply with Part 2?

# Uses of Consent Forms

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## Possible Answers:

1. Yes, because permitting disclosure of the same amount of information to all recipients simplifies the disclosures.
2. No, because not all purposes for which information is to be disclosed require the disclosure of the entire record.

# Uses of Consent Forms

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## Correct Answer

#2. Probably not. The consent form must limit the amount of information to be disclosed to each recipient. Only the amount of information that is necessary to fulfill the purpose for which it is to be disclosed may be made available. As previously noted, a payor does not usually need to see the entire record for payment purposes.

FAQ II(4)

192



# Uses of Consent Forms

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## **Multiple Parties and Purposes**

- ❑ As a practical matter, the simplest and most useful multiple party consent forms will be those that authorize the same kind and amount of information to be shared, for the same common purpose among all those authorized to receive and / or disclose that information to one another.

# Uses of Consent Forms

---

## **Merger or Restructuring**

- What if the Part 2 program disclosing information merges with another or undergoes corporate restructuring? Does a consent allowing the Part 2 program to disclose information remain in effect after the merger or corporate restructuring?

more...

FAQ II(2)

## Uses of Consent Forms

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### **Merger or Restructuring** (cont.)

- If the consent form identified the disclosing party by **general designation** not name, the consent is still valid after merger or restructuring as long as that general designation still applies.

more...

# Uses of Consent Forms

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## **Merger or restructuring** (cont.)

For example,

- If the disclosing entity is identified by general designation, a consent form stating “drug or alcohol program affiliated with XYZ HIO” would still be valid if the program that merged or underwent corporate restructuring is still affiliated with the HIO.

more...

# Uses of Consent Forms

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## Poll / Scenario

If the disclosing entity is identified on the consent form as ABC Treatment Program, and after merger its name is changed to EFG Treatment Program, is the consent still valid?

# Uses of Consent Forms

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## Possible Answers:

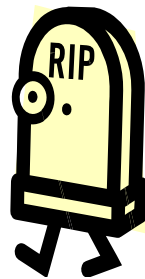
1. Yes, because the program still exists, it is just called by a different name.
2. No, because the name of the program on the consent has changed, and a program by that name no longer exists.

# Uses of Consent Forms

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## Correct Answer

#2. No. The consent form identified the program by name and a program by that name no longer exists.



# Uses of Consent Forms

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## **Merger or restructuring** (cont.)

What if the recipient merges with another or undergoes corporate restructuring?

- Recipients must be listed by name or title of the individual or the name of the organization.
  - If the name of the organization is listed, and after merger or corporate restructuring an entity by that name no longer exists, then the consent form would no longer be valid.
  - If the name or title of an individual is listed, and that person still works for the merged or restructured entity, the consent remains valid.




# HAVE QUESTIONS?

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**Now for your  
questions...**





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What constitutes a redisclosure?  
How can information be redisclosed?  
What are the requirements for  
notices prohibiting redisclosure?

## **3. REDISCLOSURE:**

# Redisdisclosure

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When Part 2 information is disclosed with consent to a recipient, which could be a HIO, the recipient is prohibited from redisclosing the information except:

- ▣ with the express written consent of the person to whom it pertains or
- ▣ as otherwise permitted by Part 2

more...

# Redisclosure

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When would a HIO be permitted to redisclose Part 2 information without consent “as otherwise permitted by Part 2”?

- ❑ in a medical emergency (medical emergencies will be discussed in Webinar #3) or
- ❑ when no patient identifying information is disclosed.

more...

# Redisdisclosure

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“Non-patient identifying” information is information that does not identify an individual as having a current or past drug or alcohol problem, or as a participant in a Part 2 program.

For example, a HIO could, without consent, redisclose:

- ▶ demographic information that does not reveal patient identifying information
- ▶ aggregated information that does not include patient identifying information

# Redisdisclosure

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A HIO may not redisclose protected Part 2 information for Disease Management purposes without patient consent authorizing such a redisclosure, unless no patient identifying information is revealed.

# Notice Prohibiting Redisclosure

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Each disclosure of Part 2 information made with written patient consent must be accompanied by a notice prohibiting redisclosure.

more...

# Notice Prohibiting Redisclosure

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The notice must read:

“This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”



# Notice Prohibiting Redisclosure

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- When information is disclosed electronically, the written notice explaining the prohibition on redisclosure must be sent electronically with Part 2 records.
  - So, a notice prohibiting redisclosure must accompany any disclosure by a Part 2 Program to a HIO, and must accompany any redisclosure of Part 2 information by a HIO to any entity receiving information.

# Notice Prohibiting Redisclosure

It is NOT sufficient under Part 2 to put the notice prohibiting redisclosure on a logon or splash page on the HIO's portal.

What is a logon or splash page?

- Logon page: page where a user logs onto a computer system.
- Splash page: introductory page to a website.

More...

# Notice Prohibiting Redisclosure

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Putting the notice prohibiting redisclosure on a logon or splash page is not sufficient because:

- the notice must be tied to the Part 2 information being disclosed so that the recipient of the information knows that specific information is protected by Part 2 and cannot be redisclosed except as authorized by the express written consent or as otherwise permitted by Part 2.

# Notice Prohibiting Redisclosure

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Therefore, it is important that an HIE system has the technical capacity to segregate or flag Part 2 information.





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## 2. Consent Requirements for Minors

# Requirements for Minors

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- A minor's consent is **always** required for a Part 2 program to disclose patient identifying records to a HIO or any other entity.
- State law governs whether a parent's or guardian's consent is also required.

more...

# Requirements for Minors

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- If the state law requires programs to get parental consent before providing treatment to a minor, parental consent for disclosure is also required.
- If state law does not require parental consent for treatment of a minor, it does not require parental consent for disclosure either.



The End.

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# Resources

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- ❑ To order “Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA” by The Legal Action Center:

<http://www.lac.org/>

- ❑ **42 CFR Part 2 Regulation**

<http://cfr.law.cornell.edu/cfr/cfr.php?title=42&type=part&value=2>

- ❑ **HIPAA and 42 CFR Part 2 Crosswalk**

<http://www.tcada.state.tx.us/HIPAA/Crosswalk.pdf>

- ❑ [jwesloh@hazelden.org](mailto:jwesloh@hazelden.org)

- ❑ [www.samhsa.gov](http://www.samhsa.gov) – go to publications

- ❑ [www.matrixinstitute.org](http://www.matrixinstitute.org)

- ❑ [PSATTC/UCLA ISAP -](http://www.attcnetwork.org)

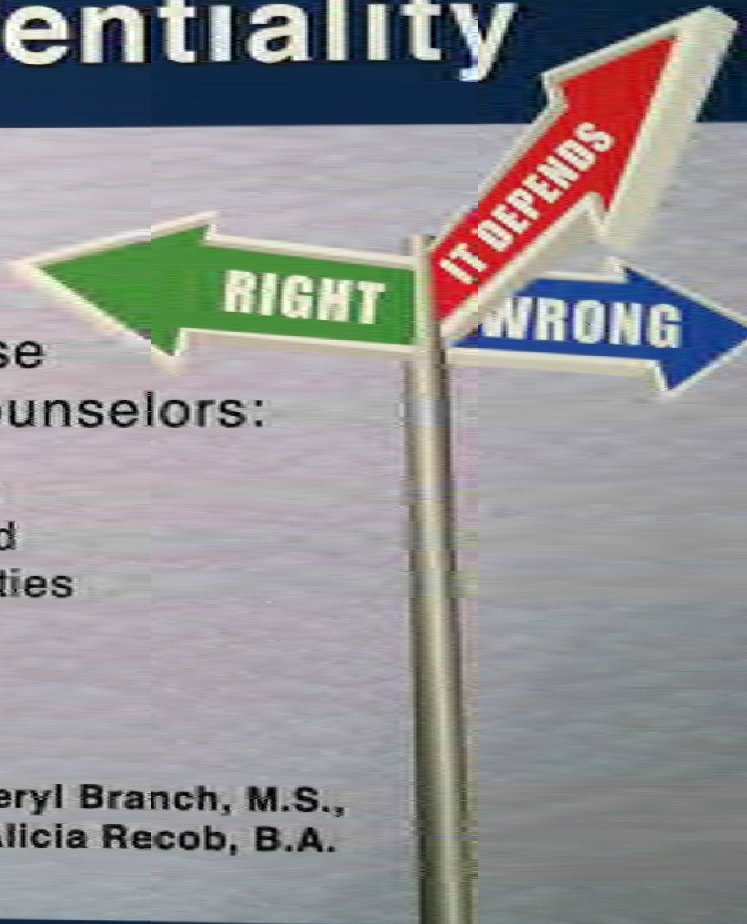
[http://www.attcnetwork.org/regcenters/index\\_pacificsouthwest.asp](http://www.attcnetwork.org/regcenters/index_pacificsouthwest.asp)

# Ethics, Laws, and Confidentiality

Guidelines for  
Substance Abuse  
& Addictions Counselors:

Understanding Your  
Personal, Legal, and  
Ethical Responsibilities

Lou Hughes, Ph.D., Cheryl Branch, M.S.,  
Patrick Hughes, B.A., Alicia Recob, B.A.  
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