

## **Appendix A - Legal and Ethical Issues**

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Screening any population for substance abuse raises key legal and ethical concerns: how one can inquire about an individual's alcohol and drug use while continuing to respect that person's autonomy and privacy. Screening of older adults for substance abuse brings these concerns into particularly sharp focus - whether the person screening is a clinician, a staff member at a senior center, a member of the clergy, an adult protective service worker, a Meals-On-Wheels volunteer, a pharmacist, a community health worker, an adult day care worker, or staff member at a long-term care facility.

This appendix examines how the issues of autonomy and privacy (or confidentiality) affect the way providers working with older adults may screen for substance use problems. The first section discusses the relationship between patient or client autonomy and the provider's obligation to inform and counsel the older individual about the health risks of alcohol or other drug use. The second section concerns privacy of information about substance use problems: How can a provider keep accurate records and communicate with others concerned about the older individual's welfare without disclosing information that may subject the individual to scorn or create problems with family or third-party payers?

### **Autonomy and the Provider's Mission: A Dilemma**

Americans attach extraordinary importance to being left alone. We pride ourselves on having perfected a social and political system that limits how far the government - and others - can control what we do. The principle of autonomy is enshrined in our Constitution, and our courts have repeatedly confirmed our right to make our own decisions for ourselves.

Most of us cherish our autonomy and fear its loss, particularly as we age. Although providers who screen or assess for substance abuse do so because they are genuinely concerned about an individual's health or functioning, screening means seeking very personal information - an unavoidable intrusion on a person's autonomy and privacy. Alert to suggestions that their judgment or abilities are impaired, older adults may not always see a provider's effort to "help" as benign.

Performed insensitively, screening or assessment may intensify denial. A person of any age who is "in denial" may not realize, or want to realize, that he has to cut back on or give up his intake of alcohol or prescription medications; an older person may view the provider's questions and suggestions as intrusive, threatening, and offensive. Suggestions that an older individual's complaint has an emotional basis may tap an underlying reluctance to acknowledge an emotional component to any problem and reinforce the individual's resistance. Because the substance abuse label carries a powerful stigma, an older individual may become alarmed if a provider intimates that alcohol or drug abuse may be involved. It will be tempting for the older individual to point

to the "normal" infirmities of old age as the source of his difficulty rather than acknowledge a problem with alcohol or other drugs.

How can the provider raise the question of alcohol and drug use constructively, without eliciting a defensive response? Should she raise the issue and then drop it at the slightest hint of resistance on the part of the older individual? Or should she intervene more forcefully - with argument or by involving the family?

To fulfill her ethical responsibility, the provider should do more than simply raise the issue. As the Consensus Panel suggests, most older adults are unaware that their metabolism of alcohol and prescription drugs changes as they age and that lower amounts of alcohol and medicines may incapacitate them. Respect for a person's autonomy means informing him of all relevant medical facts and engaging him in a discussion about his alternatives. If there is a substance abuse problem, the provider can supply the information and encouragement, but only the person with the problem has the power to change what he is doing. Respecting the patient's autonomy - his right to make choices - is central to encouraging that change.

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## **Privacy and Confidentiality**

Aside from perceived threats to autonomy, an older person may also be concerned about the practical consequences of admitting a substance use problem. Such patients may find it difficult or impossible to obtain coverage for hospitalization costs if an insurer or health maintenance organization (HMO) learns that their traumatic injuries were related to alcoholism. Relationships with a spouse, children, grandchildren, or friends may suffer. Adverse consequences such as these may discourage patients with substance use problems from seeking treatment.

Concern about privacy and confidentiality is fueled by the widespread perception that people with substance use disorders are weak and/or morally impaired. For an older person, this concern may well be compounded by an apprehension that others may view acknowledgment of a substance use disorder as a sign of inability to continue living independently. If the individual is having family problems - with a spouse or with children - information about substance use could have an adverse impact on resolution of those problems. Or the individual may experience difficulties with health insurance.

## **Federal Law**

The concern about the adverse effects that social stigma and discrimination have on patients in recovery (and how those adverse effects might deter people from entering treatment) led the Congress to pass legislation and the U.S. Department of Health and Human Services to issue a set of regulations to protect information about individuals' substance abuse. The law is codified at 42 U.S.C. § 290dd-2. The implementing Federal regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," are contained in 42 CFR Part 2 (Vol. 42 of the Code of Federal Regulations, Part 2).

The Federal law and regulations severely restrict communications about identifiable individuals by "programs" providing substance use diagnosis, treatment, or referral for

treatment (42 CFR§ 2.11). The purpose of the law and regulations is to decrease the risk that information about individuals in recovery will be disseminated and that they will be subjected to discrimination and to encourage people to seek treatment for substance use disorders.

In most settings where older adults receive care or services, Federal confidentiality laws and regulations do not apply.<sup>1b</sup> Providers should be aware, however, that if a health care practice or social service organization includes someone whose primary function is to provide substance abuse assessment or treatment and if the practice or organization benefits from "Federal assistance,"<sup>2</sup> that practice or organization must comply with the Federal law and regulations and implement special rules for handling information about patients who may have substance abuse problems.<sup>3</sup>

Moreover, the fact that most providers for older adults are not subject to the Federal rules does not mean that they can handle information about their clients' substance use problems in a cavalier manner. Because of the potential for damage, providers should always handle such information with great care.

## **State Law**

Although Federal rules do not restrict how most providers gather and handle information about an older individual's substance abuse, there are other rules that may limit how such information may be handled. State laws offer some protection to medical and mental health information about patients and clients. Most doctors, social service workers, and clients think of these laws as the "doctor-patient privilege" or "social worker-client privilege" or "psychotherapist-patient privilege."

Strictly speaking, these privileges are rules of evidence that govern whether a professional provider can be asked or compelled to testify in a court case about a patient or client. In many States, however, laws offer wider protection. Some States have special confidentiality laws that explicitly prohibit physicians, social workers, psychologists, and others from divulging information about patients or clients without consent. States often include such prohibitions in professional licensing laws; such laws generally prohibit licensed professionals from divulging information about patients or clients, and they make unauthorized disclosures grounds for disciplinary action, including license revocation.

Each State has its own set of rules, which means that the scope of protection offered by State law varies widely. Whether a communication is "privileged" or "protected" may depend on a number of factors:

1. The type of professional provider holding the information and whether he or she is licensed or certified by the State
2. The context in which the information was communicated
3. The context in which the information will be or was disclosed
4. Exceptions to any general rule protecting information, and
5. How the protection is enforced.

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## **Professionals covered by the "doctor-patient" or "therapist-client" privilege**

Which professions and which practitioners within each profession are covered depends on the State where the professional practices. California, which grants its citizens "an inalienable right to privacy" in its Constitution, has what may be the most extensive protections for medical (including mental health) information. California law protects communications with a wide variety of professionals, including licensed physicians, nurses, and psychotherapists (which includes clinical social workers, psychologists, marriage and family counselors), as well as many communications with trainees practicing under the supervision of a number of these professionals. A California court has held that information given to an unlicensed professional by an uneducated patient may be privileged if the patient reasonably believes the professional is authorized to practice medicine.<sup>4</sup>

Other States' laws cover fewer kinds of professionals. In Missouri, for example, protection is limited to communications with State-licensed psychologists, clinical social workers, professional counselors, and physicians.

Depending on their professional training (and licensing), primary care physicians, physician assistants, nurse-practitioners, nurses, psychologists, social workers, and others may be covered by State prohibitions on divulging information about patients or clients. Note that even within a single State, the kind of protection afforded information may vary from profession to profession. Professional providers should learn whether any confidentiality law in the State where they practice applies to their profession.

## **The context in which the information was communicated**

State laws vary tremendously in this area, too. Some States protect only the information that a patient or client communicates to a professional in private, in the course of the medical or mental health consultation. Information disclosed to a clinician in the presence of a third party (like a spouse) is not protected. Other States, such as California, protect all information the patient or client tells the professional or the professional gains during examination.<sup>5</sup> California also protects other information acquired by the professional about the patient's mental or physical condition, as well as the advice the professional gives the patient.<sup>6</sup> When California courts are called upon to decide whether a particular communication of information is privileged, State law requires them to presume that it is.

California affords great protection to communications between patients and psychotherapists, a term that covers a wide range of professions. Not only are communications by and to the patient protected, information communicated by a patient's intimate family members to therapists and psychiatric personnel<sup>7</sup> is also protected. California also protects information the patient discloses in the presence of a third party or in a group setting.

Understanding what medical information is protected requires professional providers to know whether State law recognizes the confidentiality of information in the many contexts in which the professional acquires it.

## **Circumstances in which "confidential" information is protected from disclosure**

Some States protect medical or mental health information only when that information is sought in a court proceeding. If a professional divulges information about a patient or client in any other setting, the law in those States will not recognize that there has been a violation of the individual's right to privacy. Other States protect information in many different contexts and may discipline professionals who violate their patients' privacy, allow patients to sue them for damages, or criminalize behavior that violates patients' privacy. The diversity of State rules in this area compounds the difficulty professionals face in becoming knowledgeable about what rules apply to them.

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## **Exceptions to State laws protecting medical and mental health information**

### **Consent**

All States permit health, mental health, and social service professionals to disclose information if the patient or client consents. However, each State has different requirements regarding consent. In some States, consent can be oral; in others, it must be written. States that require written consent sometimes require that certain elements be included in the consent form or that everyone use a State-mandated form. Some States have different consent forms with different requirements for particular diseases.

### **Other exceptions**

Consent is not the only exception. All States also require the reporting of certain infectious diseases to public health authorities and some require the reporting of elder abuse to protective service agencies, although definitions of "infectious disease" and "elder abuse" vary. And most States require health care professionals and mental health counselors to report to the authorities threats patients make to inflict harm on others. There are States that permit or require health care professionals to share information about patients with other health care professionals without the patients' consent, but some limit the range of disclosure for certain diseases, like HIV. Most States make some provision for communicating information to health insurance or managed care companies.

Many of the situations that physicians and social service workers face daily - processing health claims or public benefit applications, for example - are covered by one of these exceptions. To fully understand the "rules" regarding privacy of medical and mental health information, professionals must also know about the exceptions to those rules. Those exceptions are generally in the statute books - in either the sections on evidence or the professional licensing sections, or both. The state licensing authority as well as professional associations can usually help answer questions about State rules and the exceptions to those rules.

## **Enforcing confidentiality protections**

### **The role of the courts**

To determine the "law" - that is, the rule one must follow - in any particular area, an attorney will search for statutes, regulations, administrative rulings, and court decisions.

There is no question that in this country, the courts play a large role in "making" law - particularly in an area like privacy, which involves human behavior, shades of meaning, and intent. No legislator drafting a statute (or bureaucrat drafting a regulation) can foresee all the circumstances under which it may be applied. When one party sues another, a court is forced to decide whether a provider's disclosure of medical information was appropriate or whether such information should be disclosed during the lawsuit itself.

For example, after a car crash, the drivers may sue each other and ask the court to order the disclosure of medical records. Or the victim of an assault by an adolescent may sue the parents and seek disclosure of medical records to prove they knew their child was dangerous. How a court decides whether to order disclosure in such cases will depend on a variety of factors, including State law and regulation, court rules, and the relevance of the information sought to the dispute at hand. Similarly, when a patient or client sues a professional for releasing information to someone without her consent, the court will be called upon to weigh a variety of factors to decide whether the disclosure violated what the State recognizes as the patient's privacy.

Over time, court decisions like these add flesh to the bare statutory and regulatory rules and suggest how those rules will be applied the next time. When a difficult case arises that does not fit neatly within the rule of law as understood, it may be helpful to consult with an attorney familiar with the rules and how the State's courts are likely to interpret them.

### **Penalties for violations**

States differ in the ways they discipline professionals for violations of patients' or clients' privacy. In some States, violation of confidentiality is a misdemeanor, punishable by a fine or short jail term. In many States, the professional licensing agency has the power to bring disciplinary charges against a professional who violates a client's privacy. Such charges may result in censure or license suspension or revocation. Finally, the State may permit the aggrieved patient or client to sue the professional for damages caused by the violation of his right to confidentiality.

The reality is, these enforcement mechanisms are rarely used. States rarely prosecute privacy violation offenses and professional disciplinary committees in most States are more concerned with other kinds of professional infractions. That is not to say that violation of a patient's privacy is cost-free. A patient or client who thinks he has been hurt by a professional's indiscretion is free to sue; while such cases are difficult for clients to win, they can cause the professional and the organization employing her a good deal of grief - financial, emotional, and professional. Even short of litigation, no professional wants to acquire the reputation of being thoughtless or indiscreet.

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## **Strategies for Dealing With Common Situations**

### **Charting substance use information**

One way for a professional to safeguard clients' privacy and avoid breaking the rules is to develop a charting, or record-keeping, system that is accurate but still protects clients' rights to privacy and confidentiality. It is important to remember how many people could see a client's medical, mental health, or social service record. A medical chart, for example, will be seen by the medical office staff, the insurance company (or HMO or managed care organization [MCO]), and in the event of a referral, another set of clinicians, nurses, clerical workers, and insurers. If the patient is involved in litigation and his medical or mental health is in issue, the court will most likely order disclosure of his chart or file in response to a subpoena.

When a provider documents the results of substance abuse screening or assessment or flags an issue to be raised the next time he sees the client, he should use neutral notations or reminders that do not identify the problem as being substance-use-related. Following are three record-keeping systems that comply with the stringent Federal confidentiality regulations, protect clients' autonomy and privacy, and can be used in a wide variety of settings (TIP 16, Alcohol- and Other-Drug Screening of Hospitalized Trauma Patients, CSAT, 1995):

- The "minimalist" approach, which relies on the provider to enter only that information in the chart that is required for accuracy and to use neutral terms wherever possible.
- The "rubber band" approach, which segregates substance abuse information in a separate "confidential" section in the chart. Information in this section would be shared with other providers only on a need-to-know basis, without being open to the view of every staff person who picked up the chart.
- The "separate location" approach, which keeps sensitive information separate from the rest of the client's chart. The other place might be a locked cabinet or other similarly secure area. A "gatekeeper" familiar with the provider's record-keeping system and the reasons for the extra security would be responsible for deciding when others - within or outside the office - will have access to this information. This approach provides, in effect, a stronger "rubber band" than that described in the second approach.<sup>8</sup>

The push toward computerization of medical records will complicate the problem of keeping sensitive information in medical records private. Currently, there is protection afforded by the cumbersome and inefficient way many, if not most, medical, mental health, and social service records make their way from one provider to another. When records are stored in computers, retrieval can be far more efficient. Computerized records may allow anyone with a disc and access to the computer in which the information is stored to instantly copy and carry away vast amounts of information without anyone's knowledge. Modems that allow communication about patients among different components of a managed care network extend the possibility of unauthorized access to anyone with a modem, the password(s), and the necessary software. The ease with which computerized information can be accessed can lead to "casual gossip" about a client, particularly one of importance in a community, making privacy difficult to preserve.

### **Communicating with others**

One of the trickiest issues is whether and how providers of older adults health care should communicate with others about their clients' substance use problems. Communications with others concerned about the client may confirm the provider's judgment that the client has a substance use problem or may be useful in persuading a reluctant client that treatment is necessary.

Before a provider attempts to gather information from other sources or enlist help for a patient or client struggling with recovery, he should ask the older client's permission to do so. Speaking with relatives (including children), doctors, or other health and mental health professionals not only intrudes on the client's autonomy, it also poses a risk to her right to privacy. Gathering information (or responding to questions about a client's problems) from a spouse, child, or other provider can involve an explicit or implicit disclosure that the provider believes the client or patient has a substance use problem. And the provider making such a disclosure may be inadvertently stepping on a land mine.

Making inquiries or answering questions behind the client's back may seriously jeopardize the trust that has developed between the provider and the client and undermine his attempt to offer help. The professional who talks to the client's son and then confronts her with their joint conclusions runs the risk that he will damage his relationship with the client. Feeling she can no longer trust the provider and angry that he has shown little respect for her autonomy or privacy, the client may refuse to participate in any further discussions about her problems.

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### **Dealing with questions of incapacity**

Most older clients or patients are fully capable of comprehending the information and weighing the alternatives offered by a provider and making and articulating decisions. A small percentage of older patients or clients are clearly incapable of participating in a decision-making process. In such cases, the older person may have signed a health care proxy or may have a court-appointed guardian to make decisions in his stead.

The real difficulty arises when a provider is screening or assessing an older person whose mental capacity lies between those two extremes. The client or patient may have fluctuating capacity, with "good days" and "bad days" or periods of greater or lesser alertness depending upon the time of day. His condition may be transient or deteriorating. His diminished capacity may affect some parts of his ability to comprehend information but not others.

How can the provider determine whether the patient or client understands the information she is presenting, appreciates the implication of each alternative, and is able to make a "rational" decision, based on his own best interests? There is no easy answer to this question. One can, however, suggest several approaches.

*Maximizing autonomy.* The provider can help the patient or client who appears to have diminished capacity through a gradual information-gathering and decisionmaking process. Information the client needs should be presented in a way that allows the patient or client to absorb it gradually. The provider should clarify and restate information

as necessary and may find it helpful to summarize the issues already covered at regular intervals. Each alternative and its possible consequences should be laid out and examined separately. Finally, the provider can help the client identify his values and link those values to the alternatives presented. By helping the patient or client narrow his focus and proceed step-by-step, the provider may be able to assure herself that the client, despite his diminished capacity, has understood the decision to be made and acted in his own best interest.

*Enlisting the help of a health or mental health professional.* If working with the patient or client in a process of gradual information-gathering and decision-making is not making headway, the provider can suggest that together they consult a health or mental health professional. Perhaps there is someone who has known the patient or client for a number of years who has a grasp of the client's history and better understanding of the obstacles to decision-making. Or, the provider may suggest a specialist who can help determine why the patient is having difficulty and whether he has the capacity to make this kind of decision.

*Enlisting the help of family or close friends.* Another approach is for the provider to suggest to the patient or client that they call in a family member or close friend who can help them organize the information and sort through the alternatives. Asking the client who he thinks would be helpful may win his endorsement of this approach.

*When the client cannot grasp the information or come to a decision.* If the provider's efforts to inform the patient or client and help him reach a decision are unsuccessful, she might seek his permission to consult a family member or close friend to discuss the problem. If the client consents, the provider should lay out her concerns for the family member or friend. It may be that the client has already planned for the possibility of his incapacity and has signed a durable power of attorney or a health care proxy.

*Guardianship.* A guardian<sup>9</sup> is a person appointed by a court to manage some or all aspects of another person's life. Anyone seeking appointment of a guardian must show the court (1) that an individual is disabled in some way by disease, illness, or senility, and (2) that the disability prevents him from performing the tasks necessary to manage an area or areas of his life.

Each state handles guardianship proceedings differently, but some principles apply across the board: Guardianship is not an all-or-nothing state. Courts generally require that the person seeking appointment of a guardian prove the individual's incapacity in a variety of tasks or areas. Courts may apply different standards to different life tasks - managing money, managing a household, making health care decisions, entering contracts. A person may be found incompetent to make contracts and manage money but not to make his own health care decisions (or vice versa), and the guardianship will be limited accordingly.

Guardianship diminishes the older adult's autonomy and is an expensive process. It should, therefore, be considered only as a last resort.

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**Making referrals to substance abuse treatment programs**

The provider has persuaded the patient or client to try outpatient treatment and knows the director of an excellent program in the immediate area. Rather than simply picking up the phone and letting the director know she has referred the patient, she should consult the patient about the specific treatment facility. Though it may seem that consent to treatment is the same as consent to referral to a particular facility, it takes very little time to get the patient's consent, demonstrates respect for the client or patient, and protects the provider if, say, the treatment program's director is a relative or has some other connection to the client.

### **Communications with insurers, HMOs, and other third-party payers**

The structure of health, mental health, and ancillary social service care for older adults is changing rapidly. Of course, older adults are covered by Medicare, but many have supplementary insurance or have joined HMOs or are entitled to government-sponsored social services because of particular medical, physical, or mental disabilities. How should the professional provider communicate with these different types of entities?

Traditional health insurance programs offering reimbursement to patients for health care expenditures typically require patients to sign claim forms containing language consenting to the release of information about their care. The patient's signature authorizes the practitioner to release such information. Although HMOs do not require patients to submit claim forms, both practitioners and patients understand that the HMO or MCO can review clinical records at any time and may well review records if it has questions about the patient's or client's care.

Should the provider rely on the patient's signed consent on the health insurance form or the HMO contract and release what she has in her chart (or a neutral version of that information)? Or should she consult the patient?

The better practice is for the provider to frankly discuss with the patient what information she intends to disclose, the alternatives open to the client (disclosure and refusal to disclose), and the likely consequences of those alternatives. Will the information the provider sends explicitly or implicitly reveal the nature of the patient's problem? Does the client's chart contain a substance abuse diagnosis? Once again, the provider confronts the question of how such information should be recorded. Has she balanced the need for accuracy with discretion and a respect for patients' privacy? Finally, even if the chart or file contains explicit information about the client's substance use problem, can the provider characterize the information and her diagnosis in more neutral terms when releasing information to the third-party payer?

Once the client understands what kind and amount of information the provider intends to send a third-party payer, he can decide whether to agree to the disclosure. The provider should explain that if she refuses to comply with the third-party payer's request for information, it is likely that at least some related services will not be covered. If the client expresses concern, she should not mislead him, but confirm that once a third-party payer learns he has had a substance use problem, he could and may lose either some of his insurance coverage or parts of other entitlements and be unable to obtain other coverage.<sup>10</sup>

The final decision should be the client's. He may well decide to pay out of pocket. Or he may agree to the limited disclosure and ask the provider to inform him if more information is requested.

As managed care becomes more prevalent throughout the country, medical and mental health providers are finding that third-party payers demand more and more information about patients and about the treatment provided to those patients in order to monitor care and contain costs. Providers need to be sensitive about the amount and kind of information they disclose because there is a risk that this information may be used to deny future benefits to the client. Chart notes may also contain detailed and very personal information about family life that may be unnecessary for a third-party payer to review in order to determine whether and what kind of treatment should be covered.

As in so many other areas involving patients' privacy, it is best to follow two simple rules: First, keep notations and documentation as neutral as possible while maintaining professionally acceptable standards of accuracy. Second, consult the client and let the client decide whether to agree to the disclosure.

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### **Communicating with the legal system**

If a doctor, psychologist, social worker, or other provider gets a call from a lawyer asking about a patient or client, or a visit from a law enforcement officer asking to see records, or a subpoena to testify or produce medical records, what should he or she do? As in other matters of privacy and confidentiality, (1) consult the patient, (2) use common sense, and (3) as a last resort, consult State law (or a lawyer familiar with State law).

*Responding to lawyers' inquiries.* Say a lawyer calls and asks about Emma Bailey's medical, mental health, or social service history or treatment. As a first approach to the question, the provider could tell the lawyer, "I don't know that I have a client with that name. I'd have to check my records"<sup>11</sup> or tell the caller that he must consult with his client before having a conversation about her: "I'm sure you understand that I am professionally obligated to speak with Emma Bailey before I speak with you." It will be hard for any lawyer to disagree with this statement.

The provider should then ask the client if she knows what information the caller is seeking and whether the client wants him to disclose that or any other information. He should leave the conversation with a clear understanding of the client's instructions - whether he should disclose the information, and if so, how much and what kind. It may be that the lawyer is representing the client in a case and the client wants the provider to share all the information he has. On the other hand, the lawyer may represent someone with whom the client has a dispute. There is nothing wrong with refusing to answer a lawyer's questions.<sup>12</sup>

If the lawyer represents the client and the client asks the provider to share all information, the provider can speak freely with the lawyer. However, if the provider is answering the questions of a lawyer who does *not* represent the client (but the client has consented to the disclosure of *some* information), the provider should listen carefully to

each question, choose his words with care, limit each answer to the question asked, and take care not to volunteer information not called for.

*Visits by law enforcement.* A police officer, detective, or probation officer who asks a provider to disclose medical, mental health, or social service information about a client or a client's case records can usually be handled in a similar manner:<sup>13</sup> The provider can safely tell the officer, as he might a lawyer, "I'm sure you understand that I am professionally obligated to speak with my patient before I speak to you."<sup>14</sup>

The provider should then speak with the client to find out whether she knows the subject of the officer's inquiry, whether she wants the provider to disclose information and if so, how much and what kind. The caretaker might end the conversation by asking whether there are any particular areas the client would prefer he not discuss with the officer.

When a law enforcement officer comes armed with a search warrant, the answer is different. In this case, the provider has no choice but to hand over the records listed in the warrant.

*Responding to subpoenas.* Subpoenas come in two varieties. One is an order requiring a person to testify, either at a deposition out of court or at a trial. The other - known as a subpoena duces tecum - requires a person to appear with the records listed in the subpoena. Depending on the State, a subpoena can be signed by a lawyer or a judge. Unfortunately, it cannot be ignored.

In this instance, the provider's first step should be to call Emma Bailey - the client about whom he is asked to testify or whose records are sought - and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of Emma's lawyer, with Emma's consent. However, it is equally possible that the subpoena has been issued by or on behalf of the lawyer for an adverse party. If that is the case, the provider's best option is to consult with Emma's lawyer to find out whether the lawyer will object - ask the court to "quash" the subpoena - or whether the provider should simply get the client's consent to testify or turn over her records.<sup>15</sup> An objection can be based on a number of grounds and can be raised by any party as well as by the person whose medical information is sought. If the provider is covered by a State statutory privilege, he may be able to assert the client's privilege for her.

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## **Conclusion**

It is essential for those who work with older adults to respect their clients' autonomy and rights to privacy and confidentiality if they are to be effective in screening and assessing clients for substance use disorders and persuading them to cut down their use or enter treatment. In most situations, providers can follow these simple rules: (1) consult the client, (2) let the client decide, and (3) be sensitive to how information is recorded or disclosed. It is only as a last resort that the provider will have to consult State law or a lawyer.

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<sup>1b</sup> For many years, there was confusion about whether general medical care settings such as primary care clinics or hospital emergency rooms were subject to the Federal law and regulations because they provided substance abuse diagnosis, referral, and treatment as part of their services. In 1995, DHHS revised the definition of the kinds of "programs" subject to the regulations that made it clear that *the regulations do not generally apply to a general medical care facility* unless that facility (or person) holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment . . . (42 CFR§ 2.11).

The full text of § 2.11 now reads:

Program means:

(a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or

(b) An identified unit within a general medical facility which holds itself out as providing and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or

(c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers. (See § 2.12(e)(1) for examples.)

60 Federal Register 22,297 (May 5, 1995).

<sup>2</sup> The regulations provide that "federally assisted" programs include:

- Programs run directly by or under contract for the Federal government;
- Programs carried out under a Federal license, certification, registration, or other authorization, including certification under the Medicare Program, authorization to conduct a methadone maintenance treatment program, or registration to dispense a drug that is regulated by the Controlled Substances Act to treat alcohol or drug abuse;
- Programs supported by any federal department or agency of the United States, even when the federal support does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities;
- Programs conducted by State or local government units that are supported by Federal funding that could be (but is not necessarily) spent for the substance abuse treatment program;
- Tax-exempt programs.

42 C.F.R. § 2.12(b).

<sup>4</sup> *Luhndorff v. The Superior Court of Tulare County*, 166 CA 3d 485, 212 Cal. Rptr. 516 (5th District, 1985). Interestingly, *Luhndorff* was a criminal case in which the prosecution sought the records of an unlicensed social worker who interviewed the defendant, diagnosed his problem, determined the appropriate treatment, and treated him for 3

months. The social worker was working under a licensed individual's supervision. The defendant thought the social worker was a psychiatrist.

<sup>5</sup> Section 451 of the California Evidence Code codifies the doctor-patient privilege. See *Grosslight v. Superior Court of Los Angeles*, 42 CA 3d 502, 140 Cal. Rptr. 278 (1977), in which the court held that information communicated by the parents of a minor psychiatric patient to her doctor and his secretary was privileged, even though the parents were being sued by someone the child injured on the theory that the parents knew their child was a danger to others.

<sup>6</sup> Note that the breadth of the protection may vary according to the clinician's profession.

<sup>7</sup> *Grosslight v. Superior Court of Los Angeles*, 72 Cal. App. 3d 502, 140 Cal. Rptr. 278 (1977), interpreting Section 451 of the California Evidence Code (see footnote 5).

<sup>8</sup> The Consensus Panel for TIP 16 noted: "Physical separation of clinical information is not unusual. Patient charts from past years are generally kept in a separate location. Physicians routinely request charts to be sent to them from this location so that they can review historical clinical information about the patient. In addition, nurses are quite accustomed to keeping some medications locked up and accessible only to designated personnel." (TIP 16, CSAT, 1995, p. 76)

<sup>9</sup> In some States, a guardian is referred to as a fiduciary, conservator, or committee. The person who has a guardian is generally called a "ward" or an "incapacitated person."

<sup>10</sup> Some States prohibit insurance companies from discriminating against individuals who have received substance abuse treatment; however, these kinds of discriminatory practices continue. Insurance companies routinely share information about applicants for life and disability insurance through the Medical Information Bureau - a data bank maintained by a private organization and supported by the industry.

<sup>11</sup> In fact, in some States, depending on the provider's profession, the identity of patients or clients as well as their records are protected. Therefore, professionals should find out whether disclosing a patient's name or acknowledging that the individual about whom the lawyer is inquiring is a client would be considered a violation of the client's right to confidentiality.

<sup>12</sup> A firm, but polite, tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the information he is asking for, and more. The clinician will not want to provoke the lawyer into taking action that will harm the patient.

<sup>13</sup> The only exception to this advice would be if the provider knew the patient was a fugitive being sought by law enforcement. In that case, in some States, a refusal to assist or give officers information might be a criminal offense.

<sup>14</sup> As noted above, in those States where the identity of clients or patients as well as their medical or mental health records are protected, the professional should give a noncommittal response, such as "I'll have to check my records to see whether I have such a patient."

<sup>15</sup> In most instances, the provider is not legally required to notify the client or get his consent to release records that have been subpoenaed. However, notifying the client shows respect for his autonomy and privacy and gives him an opportunity to object to the subpoena.