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CONFIDENTIALITY OF ALCOHOL AND OTHER DRUG ABUSE TREATMENT INFORMATION FOR EMERGENCY DEPARTMENT AND TRAUMA CENTER PATIENTS

Richard C. Boldt

Most persons who receive services related to the diagnosis and treatment of substance use disorders are protected by confidentiality rules that far exceed the privacy protections provided to virtually all other recipients of health-care services. A set of federal laws and implementing regulations restrict the disclosure of information about the treatment of alcohol and other drug (AOD) use disorders. These laws and regulations contain safeguards that are significantly more protective of patient confidentiality than ordinary state health privacy provisions, and are even more robust, in most respects, than those provided by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

† Professor of Law, University of Maryland School of Law. I thank Eileen Canfield, Diane Hoffmann, and Ellen Weber for their helpful comments on an earlier draft of this article. This work was supported by a research grant from the University of Maryland School of Law.


3 The federal AOD confidentiality law and regulations do not permit the disclosure of confidential information to insurance companies unless the patient has
In part, the unique legal standing accorded AOD treatment information is a response to the considerable stigma long associated with, and still attached to, substance use disorders. The disclosure of information identifying an individual as suffering from alcoholism or other drug use disorders can lead to the loss of employment, occupational licensing, or public housing. Such a disclosure can also produce legal jeopardy for the individual in the criminal justice and family law systems.

executed a detailed written consent form, while HIPAA permits these disclosures without written patient consent. HIPAA also permits disclosure without written patient consent to other health-care providers, while the federal AOD law and regulations require either written consent or otherwise limit disclosures to staff within the program who have a demonstrated need for the information in connection with the provision of AOD treatment to the patient. HIPAA also is much less rigorous with respect to the disclosure of patient-identifying information to law enforcement personnel. Security and Privacy, 45 C.F.R. §§ 164.506(a), 164.504(f)(1), 164.512(f) (2008); see also Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, (1996). Pursuant to these regulations, the Department of Health and Human Services issued regulations, entitled the Privacy Rule, to implement the Act; see C.F.R. Part 160, 164 (2002). The Office for Civil Rights within HHS has responsibility for enforcing these provisions. See Larry M. Gentilello et al., Alcohol Screening and Intervention in Trauma Centers: Confidentiality Concerns and Legal Considerations, 59 J. TRAUMA 1250, 1250-51 (2005).

4 See, e.g., Mararri v. WCI Steel, Inc., 130 F.3d 1180 (6th Cir. 1997); Teahan v. Metro-North Commuter R. Co., 951 F.2d 511 (2d Cir. 1991); see also Burch v. Coca-Cola, Co., 119 F.3d 305 (5th Cir. 1997) (claim under Title I of the ADA by manager who was terminated from employment after entering in-patient alcoholism treatment); 21 U.S.C. § 862a (2000) (providing for the exclusion of persons involved in drug-related activities from federally assisted public housing). A poll conducted in 2001 for Faces and Voices of Recovery by Peter D. Hart Research Associates found that twenty-four percent of people in recovery report having suffered employment and/or insurance discrimination, with twelve percent reporting they had personally been denied a job or promotion. See PETER D. HART RESEARCH ASSOCs., INC., THE FACE OF RECOVERY (2001), http://facesandvoicesofrecovery.org/pdf/hart_research.pdf.

5 See, e.g., Ellen M. Weber, Child Welfare Interventions for Drug-Dependent Pregnant Women: Limitations of a Non-Public Health Response, 75 UMKC L. REV. 789 (2007) (arguing that the child welfare system lacks capacity to help drug-dependent pregnant woman change their behavior). Professor Weber describes research suggesting that some “drug-using pregnant women avoid the health care system because they fear that the detection of their drug use will result in punitive actions, including the possible removal of a child from her custody.” Id. at 793, n.11 (citing Barry M. Lester et al., Substance Use During Pregnancy: Time for Policy to Catch Up with Research, 1 HARM REDUCTION J. 5 (2004), available at http://www.harmreductionjournal.com/content/1/1/5. Although the Americans with Disabilities Act provides some statutory protection against discrimination based on current alcoholism or past drug use disorders, it does not protect against discrimination based upon ongoing illegal drug abuse. See Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213, 12114 (2006).
In addition, the stringent AOD confidentiality rules are very much a product of the fact that alcohol and other drug abuse treatment services historically have been delivered in the United States in specialized (segregated) institutional settings by specialized treatment providers. The unusually restrictive rules governing the disclosure of this information were designed to insure that persons in need of treatment for substance use disorders regard that specialized treatment system as safe to access.

There is a movement underway, however, to begin “mainstreaming” the diagnosis and treatment of substance use disorders. This effort has been propelled by a conviction that integrating AOD treatment services into the broader health-care delivery system would likely reduce the stigma associated with alcoholism and other drug use disorders, by approaching those disorders as treatable conditions rather than instances of willful misconduct. In addition, proponents of mainstreaming emphasize that an integrated health-care delivery model would more effectively address the myriad ways that AOD abuse either causes other diseases or co-occurs with them. Finally, proponents point out that the misuse of alcohol and other drugs occurs across a continuum, and that only those persons whose abuse falls at

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7 The federal AOD treatment confidentiality legislation and the original implementing regulations promulgated in the 1970s by the Department of Health, Education and Welfare set out policy objectives that reflect both a concern about the negative consequences that untoward disclosure of treatment information can have for individuals with substance use disorders, given the stigma associated with these conditions, and a concern that such disclosures can do damage to the broader delivery system for AOD treatment services. See 42 C.F.R. §§ 2.1-2.67. In effect, the assumption has been that, if all treatment providers adhered to a comprehensive and rigorous confidentiality scheme, individuals with substance use disorders would be more likely to seek treatment for these highly stigmatized conditions. The protections provided by the federal laws and regulations are not held simply by the patient; instead, because of the overarching goal of promoting a general perception that this specialized system rigorously maintains patient confidentiality, the regulations generally regard the treatment program and the “treatment system” as entities presenting interests of equal importance to those of the individual patient. § 2.33. Thus, for example, in Subpart E of the regulations, which governs court orders for the disclosure of drug or alcohol abuse treatment information, judges are directed to give weight to the interests of the “treatment system” in maintaining patient confidentiality as an element of determining whether good cause exists. §§ 2.61-2.67.

8 See Gentilello et al., supra note 3, at 1250, 1253-54.

9 For example, roughly half of all cases of cirrhosis, pancreatitis, and cancers of the esophagus, larynx and mouth are attributable to alcohol abuse. See Richard Saitz, Unhealthy Alcohol Use, 352 NEW ENG. J. MED. 596, 597 (2005). In addition, alcohol abuse or dependence often co-occurs with hypertension, depression, anemia, and anxiety disorders. Id.
the more severe end of the continuum require the sort of intensive addiction treatment services that are traditionally offered in specialized, segregated programs. ¹⁰

Notwithstanding the urging of some public health and other health-care experts to begin a process of integrating AOD services by encouraging the adoption of a standard under which all patients presenting for medical care would be screened for alcohol and other drug use disorders, the diagnosis and treatment of these conditions has for the most part continued to remain confined to specialized addictions treatment services within the health-care delivery system.¹¹ One important exception to this pattern that has begun to emerge, however, involves the provision of AOD screening and other AOD treatment and referral services by medical personnel in emergency departments and trauma centers. In 2006, the Committee on Trauma (COT) of the American College of Surgeons revised its Optimal Resources Manual. The revision requires that all Level I and II trauma centers in the United States screen patients for alcohol problems and requires all Level I trauma centers to implement a protocol for providing brief counseling interventions to patients who screen positive for alcohol abuse. In effect, these provisions in the COT’s new manual require facilities to have the capacity to conduct alcohol screening and interventions in order to maintain certification as a Level I trauma center.¹²

Given the close correlation between substance use disorders and traumatic injury, it is not surprising that some emergency departments and, especially, trauma centers have taken the lead in integrating AOD diagnosis and treatment services into their broader agendas. Alcohol intoxication is the leading risk factor for injury, and alcohol misuse is present in approximately half of all trauma cases and one-quarter of

¹⁰ See Hungerford, supra note 6, at S11; see also Am. Coll. of Surgeons et al., alcohol screening and brief intervention (sbi) for trauma patients: cot quick guide 3, http://www.facs.org/trauma/publications/sbirtguide.pdf (last visited May 3, 2010) (reporting that “[f]or every U.S. adult who is dependent on alcohol, more than 6 other adults who are not dependent are at risk of or have already experienced problems from their drinking.”).


all emergency department admissions. In addition, at least twenty-five percent of patients whose injuries are associated with alcohol misuse return to the hospital for emergency care within one year of their initial visit as a consequence of new injuries. For some patients who are “problem drinkers” but who are not alcohol dependent, this pattern of recidivism can be interrupted by brief counseling interventions that leverage the obvious and apparent connection between substance misuse and injurious consequence to support positive behavioral change. Those patients who are screened as alcohol dependent upon their admission to an emergency department or trauma center by unit staff can be referred for detoxification and more intensive aftercare services.

The available data suggest that the practice of providing screening and either brief interventions or referrals for more intensive AOD

14 See Larry M. Gentilello et al., Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals, 241 ANNALS SURGERY 541, 541 (2005); Carol A. Soderstrom et al., Alcoholism at the Time of Injury Among Trauma Center Patients: Vehicular Crash Victims Compared with Other Patients, 29 ACCIDENT ANALYSIS & PREVENTION 715, 715, 719-20 (1997); see also Carol A. Soderstrom et al., Psychoactive Substance Dependence Among Trauma Center Patients, 267 JAMA 2756, 2756 (1992) (citing trauma center statistics regarding the role of alcohol in serious injuries). Much of the discussion and most of the available studies in this area concentrate on alcohol misuse and dependence. This makes sense, given that alcohol is the most frequently used drug of abuse. Indeed, more than 75,000 deaths each year in the United States are the result of alcohol problems. Ctrs. for Disease Control & Prevention, Injury Prevention & Control: Injury Response, Alcohol Screening, http://www.cdc.gov/InjuryResponse/alcohol-screening/ [hereinafter Alcohol Screening]. Nevertheless, the analysis applies with equal force to other substance use disorders. In a considerable number of cases, alcohol abuse or dependency occurs in combination with other drug misuse or dependence. In a study of drug-related emergency department visits in 2004, for example, the Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) reported that alcohol in combination with illegal drug use was involved in 338,638 emergency department visits out of a total of 1.6 million visits associated with drug misuse or abuse. OFFICE OF APPLIED STUDIES, U.S. DEP’T OF HEALTH & HUMAN SERVS., DRUG ABUSE WARNING NETWORK, 2004: SELECTED TABLES OF NATIONAL ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT VISITS (2009), https://dawninfo.samhsa.gov/files/ED2004/2004EDTables.pdf.

15 See Rosemary Frei, ACS Trauma Committee Takes Decisive Step Against Alcohol Abuse, GEN. SURGERY NEWS (2006) (on file with author).

16 On the distinction between alcohol and other drug dependency versus problem drinking and other risky drug use behaviors, see Saitz, supra note 9, at 597-98. See also infra text accompanying notes 112-117.

17 See Chris Dunn et al., The Stages of Change: When are Trauma Patients Truly Ready to Change?, 59 J. TRAUMA S27 (2005) (suggesting the Stages of Change (SOC) model enhances such interventions).

18 See Hungerford, supra note 6, at S14.
treatment can produce dramatic results. The authors of several carefully designed studies have reported "substantial decreases in reinjury rates" following the provision of brief interventions in the acute injury context. Other researchers have reported reduced rates of subsequent hospitalizations, and at least one study has documented significant cost savings associated with the implementation of screening and intervention practices.

Despite these encouraging statistics and broad support among trauma surgeons and other emergency medical personnel, many trauma centers and emergency departments still do not provide systematic screening and intervention services for all patients. One inhibitor is the persistence of state laws modeled on the Uniform Accident and Sickness Policy Provision Law, which is a model statute developed in the 1940s that allows insurance carriers to exclude coverage for treatment of injuries that are related to alcohol or other drugs. Another inhibitor is a perception on the part of some treatment providers that AOD treatment is ineffective or that treatment resources are scarce or unavailable.

Several experts have suggested, however, that the special confidentiality rules governing AOD treatment information also may have an inhibiting effect on the willingness and ability of providers to engage in systematic screening, intervention, and referral activities. These experts caution that emergency department and trauma center staff may be unwilling to undertake activities covered by the AOD confidentiality regulations because they do not want to be constrained in their ability to share information freely with other clinicians involved in the care of their patients, and do not wish to incur the considerable administrative costs associated with maintaining segregated

20 Gentilello et al., supra note 14, at 544.
21 See id. at 544, 546-47.
22 See Larry M. Gentilello et al., Effect of the Uniform Accident and Sickness Policy Provision Law on Alcohol Screening and Intervention in Trauma Centers, 59 J. TRAUMA 624, 629-30 (2005).
23 See Carol R. Schermer et al., National Survey of Trauma Surgeons' Use of Alcohol Screening and Brief Intervention, 55 J. TRAUMA 849 (2003) (finding, among other things, that twenty-five percent of trauma surgeons use formal alcohol screening questionnaires).
24 See Gentilello et al., supra note 22, at 624, 629-30.
patient files, as the AOD regulations may require. More broadly, these writers suggest that complying with the special confidentiality rules would diminish the ability of clinicians and administrators to centralize information systems and integrate treatment services. Consequently, they suggest that amendments to the federal confidentiality statute and its implementing regulations may be in order, if this first step toward mainstreaming substance use disorder treatment is to take hold.  

This article explores the confidentiality issues raised by the growing movement to provide AOD screening and interventions in emergency departments and trauma centers. First, it examines the clinical context within which hospitalized trauma patients receive, or potentially might receive, these services. Then, it analyzes the federal AOD confidentiality law and regulations to determine whether, and under what circumstances, these provisions might apply to the kinds of screening and intervention activities the COT requires. The fundamental problem identified in this analysis is that the rules inadequately address situations in which AOD information is obtained both for purposes of the medical management of patients' acute injuries or illnesses and also as part of a general program of screening and intervention. The analysis demonstrates that, even when read in the context of their promulgation history and subsequent judicial interpretation, it is not clear whether the federal AOD regulations apply to the kinds of assessment, intervention, and referral activities the COT policy contemplates. On one level, this legal indeterminacy is the result of the federal regulations' inadequate consideration of the problem of multiple functions. On another level, it reflects the failure of the drafters of these provisions to appreciate that AOD problems occur along a continuum of severity, and that persons who are not substance dependent but who nevertheless have problems associated with the misuse of alcohol or other drugs may most effectively be helped by interventions outside of the specialized addiction treatment network. Framed in this way, the precise question is whether diagnosis and counseling functions directed at individuals in the middle of the continuum and at the less severe end should be regarded as AOD "treatment" within the coverage of the regulations.

Assuming that the federal AOD confidentiality law and regulations do apply to screening and intervention activities in emergency department and trauma care settings, the article concludes with some observations about the broader question of whether the law and regulations should be revised, given the obvious benefits of mainstreaming

26 See, e.g., Gentilello et al., supra note 3, at 1253-54.
substance abuse treatment on the one hand, and the continuing stigma and legal jeopardy associated with the disclosure of AOD disorders on the other. Although creating a limited use exception for AOD screening and intervention activities when undertaken by emergency departments and trauma centers may be worth considering, this article argues that there is considerable flexibility already in the law to accommodate the interests in tension here. On balance, the best course likely will be to maintain the confidentiality regime currently in place for alcohol and other drug abuse treatment information, at least for the foreseeable future.

I. THE PROVISION OF ALCOHOL AND OTHER DRUG USE DISORDER SCREENING, ASSESSMENT AND INTERVENTION SERVICES TO HOSPITALIZED TRAUMA PATIENTS

Approximately 110 million patients are treated annually in hospital emergency departments in the United States, and at least 3.5 million injured persons are admitted for care in U.S. trauma centers each year. Research drawn from a number of samples of hospitalized trauma patients over a period of almost two decades consistently has shown that at least forty percent and as much as eighty percent of this population tests positive for alcohol or other drugs upon their admission for emergency treatment. Given the sheer number of injured patients who pass through the system and the well established evidence of a substantial co-occurrence of traumatic injury and AOD use, it is not surprising that emergency departments and trauma centers increasingly have sought to provide systematic screening, assessment, and intervention services for their patients.

Traditionally, emergency department and trauma center staff were oriented clinically toward treating their patients' presenting conditions rather than providing preventive services. More recently, however, public health experts and health-care providers within emergency departments and trauma centers have begun to adopt a "new perspective" in which accidental injury is viewed as a disease, not unlike heart disease, diabetes, or cancer. When injuries are viewed in this way, treating professionals are more likely to understand their role to

27 See Alcohol Screening, supra note 14.
include the exploration of underlying causes and the presentation of interventions designed to reduce future harm. Moreover, given the prevalence of AOD misuse among patients presenting at hospitals with accidental injuries, and given research demonstrating that patients who were intoxicated at the time of an initial injury are two and one-half times more likely than other patients to suffer re-injury within an eighteen-month period, providing AOD screening and interventions makes sense. Just as we would expect a heart attack patient to receive counseling about exercise and diet as a regular component of his or her treatment, so too should a patient who has suffered traumatic injury, due to alcohol or other drug use, receive focused interventions calculated to prevent re-injury.

The screening of patients for alcohol and other drug abuse is a preliminary step that often precedes a more intensive assessment of those individuals who have had positive screens to determine if they have substance use disorders for which treatment or other interventions are appropriate. The initial AOD screening serves a number of useful functions, which include assisting in the medical management of trauma patients and identifying persons at risk of re-injury. In addition, the screening may lead to therapeutic interventions designed to reduce AOD misuse and dependency. Such screening can be accomplished through laboratory tests, screening interviews and questionnaires, or a combination of both physical and nonphysical tests. The most commonly employed laboratory tests measure the presence of alcohol in the patient’s blood (“blood alcohol concentration” or “BAC”) or the presence of other drugs in the patient’s urine (“urine drug screening”). These tests indicate recent substance use, but do

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30 See, e.g., Frederick P. Rivara et al., The Effects of Alcohol Abuse on Readmission for Trauma, 270 JAMA 1962 (1993).
31 See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 1.
32 Screening is defined as “the application of a simple test to a group of persons for the purpose of identifying a subgroup with a certain condition.” See id. at ch. 4. Screening tests are usually described in terms of their “specificity,” which is their capacity to exclude individuals who do not have the target condition, and “sensitivity,” which is their ability “to detect the target condition in a given population when it is present.” Id.
33 Alcohol and other drug screening is important in the medical management of emergency and trauma patients in a number of respects. See id. at ch. 3. Issues with respect to anesthesia and pain management may be directly implicated by a patient’s substance abuse. Id. In addition, medical staff may be involved in providing care during withdrawal. Id.
34 Other tests include saliva tests and breathalyzer tests. See id. at ch. 4. In addition, chronic alcohol use can be determined in some instances through the use of tests that measure injury to liver cells and to the cells that manufacture red blood
not necessarily indicate either AOD dependence or chronic misuse. Consequently, many clinicians believe that laboratory test results should be interpreted alongside the results of other screening instruments. A wide variety of questionnaires and structured interviews are available for use by clinicians who wish to employ this combination of laboratory testing and other nonphysical screening tools.

Once a positive AOD screen has occurred, the patient may undergo a comprehensive assessment to determine if he or she has a substance use disorder, including chronic misuse and/or dependency, and would benefit from either a brief intervention or a referral for more intensive treatment. While most or all of the commonly used screening techniques can be employed by emergency department or trauma center personnel without specialized training in substance use disorders, assessments should be performed by a specialized clinician. The assessment process generally includes an initial encounter with the patient and may also involve follow-up sessions, if the patient remains hospitalized and other features of the assessment process warrant additional meetings. The assessor may employ well developed assessment instruments, such as the widely adopted Assessment Severity Index ("ASI"), but whether or not such a tool is used, the...
assessor’s job is to piece together a comprehensive picture of the patient’s AOD use in context. This picture is likely to include information drawn from the screening tests, the assessor’s initial interview with the patient, the patient’s medical and psychiatric histories, and his or her social, occupational, family, and legal circumstances.\(^{39}\)

Plainly, this process of gathering information raises significant confidentiality considerations. Virtually every component of the assessor’s investigation has the potential to communicate sensitive AOD-related information about the patient to others, to require the disclosure of sensitive information to the assessor, or both. Even the location of the initial interview can be tricky from a confidentiality standpoint; if, for example, the patient does not have a bed in a private hospital room. The gathering of medical and psychiatric information from the patient’s written chart or from discussions with other medical caregivers also has implications with respect to the confidentiality interests protected by the federal AOD law and regulations. And conversations with family members, friends, employers, and others pose a significant risk that information will be shared that could have serious consequences for the patient in terms of child custody, employment, criminal justice issues and the like.\(^{40}\)

The comprehensive assessment often goes beyond information gathering, and may also include the development, in appropriate cases, of a forward-looking plan of intervention. Depending on the assessor’s findings, the patient could receive little more than a brief educational intervention and advice about alcohol and other drug use and misuse, or he or she could receive an intervention, still brief in length, more explicitly focused on changing the patient’s behavior and/or preparing the patient to accept the need for more intensive longer-term AOD treatment.\(^{41}\) In some instances, the initial interview with the assessor may serve as a therapeutic intervention as well.\(^{42}\)

\(^{39}\) See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 4.

\(^{40}\) See id.

\(^{41}\) See Craig Field et al., Brief Motivational Interventions: An Introduction, 59 J. TRAUMA S21, S24-26 (2005). In foundational research conducted in the early 1960s, Chafetz found that only about one percent of emergency department patients who were referred to alcohol and other drug abuse treatment after discharge actually kept their appointment. When a brief intervention conducted by a trained AOD counselor was offered before discharge, however, the show up rate for aftercare increased to forty-two percent. Morris E. Chafetz, A Procedure for Establishing Therapeutic Contact with the Alcoholic, 22 Q.J. STUD. ALCOHOL 325, 326-27 (1961).

\(^{42}\) See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 4.
For patients who have problems with AOD use but who do not require specialized clinical services related to withdrawal from alcohol or other drugs or other intensive AOD treatment, the provision of a brief counseling intervention may make a significant difference in reducing AOD misuse and the related likelihood of future traumatic injury. A number of studies conducted in the 1980s and 1990s demonstrated that even relatively simple counseling sessions could substantially reduce alcohol consumption among heavy drinkers. In one British study, a randomly assigned group was provided information comparing individuals’ weekly alcohol intake with national averages, along with a diary to record their ongoing alcohol use. In addition, these individuals were given written information about how to moderate their drinking. Twelve months later, this study group exhibited a twofold reduction in their alcohol consumption relative to the control group.43 In another multinational study sponsored by the World Health Organization, a range of brief interventions all produced significantly reduced levels of alcohol consumption. These results held up even in the group that received the most minimal intervention and were consistent in ten different countries with widely differing cultural norms with respect to drinking.44 More recent studies of brief interventions provided within emergency departments and trauma centers have reported similar results.45

While the specific details of AOD interventions vary from one program to the next, researchers have begun to identify certain common features that appear to make these practices successful. Miller

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43 Paul Wallace et al., Randomised Controlled Trial of General Practitioner Intervention in Patients with Excessive Alcohol Consumption, 297 BRIT. MED. J. 663, 664, 666 (1988).

44 In the study sponsored by the World Health Organization, the brief interventions consisted of either a single five minute session on sensible drinking, a single fifteen minute counseling session, or a brief initial counseling session and several follow up sessions. World Health Org. [WHO], Project on Identification and Management of Alcohol-Related Problems: Report on Phase II: A Randomized Clinical Trial of Brief Interventions in Primary Health Care, at 18, 241, 243-45, WHO/PSA/91.5 (Thomas F. Babor & Marcus Grant eds., 1992), http://whqlibdoc .who.int/hq/1991/WHO_PSA_91.5.pdf.

45 See, e.g., Anne Moyer et al., Brief Interventions for Alcohol Problems: A Meta-Analytic Review of Controlled Investigations in Treatment-Seeking and Non-Treatment Seeking Populations, 97 ADDICTION 279 (2002) (summarizing “additional positive evidence for brief interventions compared to control conditions typically delivered by health-care professionals to non-treatment-seeking” individuals); see also Kari Poikolainen, Effectiveness of Brief Interventions to Reduce Alcohol Intake in Primary Health Care Populations: A Meta-Analysis, 28 PREVENTATIVE MED. 503, 503-04 (1999) (studying the effects of brief intervention delivered to the general population and patients of family or general practitioner practices).
and Sanchez have set out six elements, captured by the acronym FRAMES, that typically are found in well-designed programs. These elements are "feedback, responsibility, advice, menu, empathy, and self-efficacy." More generally, experts in this area suggest that the key to success is to motivate the patient to adopt safer AOD-related behaviors by providing objective information about past AOD use, by making the patient an active participant in setting goals for future behavior, and by providing empathic support and encouragement. In addition, interventions may involve working with the patient to identify barriers to change and to plan concrete steps that he or she can take to effectuate recovery. Perhaps most important, because the actual intervention occurs at a "teachable moment," it provides an opportunity for the patient to begin to link his or her misuse of alcohol or other drugs with the injury that has occasioned his or her hospitalization and, by extension, to link a change in that behavior with the possibility of a reduced risk of future traumatic injury.

As more emergency departments and trauma centers provide AOD-related services ranging from initial screening to comprehensive assessment to intervention, counseling, and referral activities, the question of patient confidentiality increases in salience. It may be that systematic screening of all patients, which often is accomplished by medical staff without any specialization in AOD treatment and often undertaken for multiple purposes including the medical management of trauma injuries, is subject to a different (and less demanding) set of confidentiality rules than are the assessment and counseling activities more commonly conducted by AOD specialists. Further, the applicability of the federal confidentiality regulations may depend on whether the AOD specialists who do this work formally are part of the emergency department or trauma unit staff. These and other related issues turn on the language of the federal AOD confidentiality law and regulations and the interpretations of that language that have been offered by officials at HHS and the courts. We now turn to a consideration of these materials.

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46 William R. Miller & Victoria C. Sanchez, Motivating Young Adults for Treatment and Lifestyle Change, in Alcohol Use and Misuse by Young Adults 55, 61-63 (George S. Howard & Peter E. Nathan eds., 1993).
47 See generally Field et al., supra note 41 (discussing brief motivational interventions and contrasting such methods with more traditional approaches to patient-provider interaction); see also CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 4.
48 See id.; see also AM. COLL. OF SURGEONS ET AL., supra note 10, at 9-10.
II. THE FEDERAL ALCOHOL AND OTHER DRUG TREATMENT CONFIDENTIALITY LAW AND REGULATIONS

In the early 1970s, Congress passed two statutes designed to protect the confidentiality of persons who apply for or receive treatment for alcohol or other drug use disorders. The Department of Health, Education, and Welfare ("HEW"), the agency responsible, at the time, for implementing these laws, then promulgated regulations detailing the obligations of treatment programs with respect to these statutes. In 1987, HEW's successor, the Department of Health and Human Services ("HHS"), issued a revised set of confidentiality regulations, and in 1994 the agency proposed several additional amendments. These regulations, as so amended, currently apply to all federally assisted AOD treatment programs.

In order to accomplish its dual objectives of protecting the health privacy of individual patients and the overall integrity of the specialized AOD treatment system, the current federal confidentiality law and regulations articulate a general prohibition against disclosure. Thus, unless one of a limited number of exceptions applies, the general rule is that a federally assisted AOD treatment program may not disclose any information that would identify a person as a patient who has sought or received substance abuse treatment.

The broad definitions of key terms insure that this fundamental prohibition on disclosure is both expansive and robust. Thus, the regulations define a "program" as "an individual or entity ... who holds itself [sic] out as providing, and provides, alcohol or drug abuse diag-

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51 For a discussion of these amendments, see infra text accompanying notes 74-75.

52 For a discussion of these amendments, see infra text accompanying notes 82-88.


54 See supra text accompanying note 7.

nosis, treatment, or referral for treatment." Further, the regulations define a "disclosure" as any oral or written "communication of patient-identifying information." Even the mere conformation of information that a recipient already possesses is deemed to be a disclosure. The term "patient" includes any person who has applied for or received diagnosis or treatment. "Diagnosis" is defined as "any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment." "Treatment," in turn, "means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient." In effect, a person becomes a "patient" entitled to protection under the federal regulations once he or she has received an interview, counseling, or any other related diagnostic, referral, or treatment service by a covered treatment program, even if the individual is not ultimately admitted for ongoing care. The regulations provide a limited number of exceptions to the general rule proscribing the disclosure of AOD diagnosis and treatment information. Several of these exceptions stem from the basic definitions that construct the fundamental prohibition. In order for a communication of information to be a "disclosure," and therefore subject to the federal restrictions, it must identify a person as an AOD "patient." Thus, a communication that is anonymous, that does not link an individual to an AOD treatment provider (which may be possible when the program conveys information through an "umbrella" agency such as a general hospital or county public health department),

56 § 2.11. The 1987 amendments to the regulations changed this definition to make clear that an entity will not be considered a "program" unless it "holds itself out" as providing substance abuse-related services. Id. In addition, the amended regulations added a special provision that limits their application to specialized personnel within a general hospital or community mental health center. Id. For a more detailed analysis of the effect of these amendments, and their interpretation by several courts, see infra text accompanying notes 74 to 100. A program is "federally assisted" within the meaning of the federal laws and regulations if it receives federal funds in any form (including the receipt of Medicaid or Medicare reimbursement), has a grant of tax-exempt status from the Internal Revenue Service, is licensed by the federal government, or is conducted directly by the federal government. 42 C.F.R. §§ 2.12(b).

57 § 2.11.
58 Id.
59 Id.
60 Id.
61 Id.
62 §§ 2.11, 2.12(e)(4).
or that appears in the form of aggregate data is not prohibited.\textsuperscript{63} Moreover, a communication of information that is patient-identifying is still not a prohibited disclosure if it takes place “within a program,” so long as the recipient of the protected information has a need for this information in connection with his or her duties in the provision of AOD treatment to the patient.\textsuperscript{64} Other exceptions exist for patient-identifying disclosures in cases of “medical emergency,”\textsuperscript{65} when a crime has been threatened or committed on program premises or against program staff,\textsuperscript{66} when program personnel suspect that a patient is engaged in child abuse or neglect,\textsuperscript{67} or when a court has issued a proper court order.\textsuperscript{68} Furthermore the federal regulations permit disclosure of patient information pursuant to a properly executed written patient consent form, which can be critical in the everyday operation of treatment programs.\textsuperscript{69}

In determining whether hospital emergency departments and trauma centers are subject to the federal confidentiality law and regulations, a key question is whether AOD screening, intervention, and

\begin{itemize}
  \item \textsuperscript{63} See § 2.11 (defining “patient identifying information”).
  \item \textsuperscript{64} § 2.12(c)(3). The regulations also permit the communication of patient-identifying information to outside entities that provide services in support of the program’s AOD diagnosis and treatment functions, if the outside entity enters into a “qualified service organization” agreement in which it agrees to treat any patient-identifying information it receives with full confidentiality. Essentially, this sort of an agreement brings the outside service provider into the program, thus converting the disclosure into an internal communication. § 2.12(c)(4).
  \item \textsuperscript{65} § 2.51. This exception is limited to extremely serious circumstances, and only “medical personnel” may receive patient-identifying information. See id.
  \item \textsuperscript{66} § 2.12(c)(5).
  \item \textsuperscript{67} § 2.12(c)(6). This exception permits a staff member to satisfy his or her state law reporting obligations with respect to suspected child abuse or neglect, but does not remove the federal confidentiality protections from the patient’s records upon a follow up investigation.
  \item \textsuperscript{68} §§ 2.61-2.67. Before such an order may be issued, the court must give notice to the patient and the treatment program, must follow elaborate procedures to contain disclosures attendant to the hearing process, must find “good cause” for the information to be disclosed, and must limit the disclosure accordingly. Id. These procedural and substantive requirements render this sort of an order much more difficult to obtain than other more familiar forms of compulsory process, such as warrants and subpoenas.
  \item \textsuperscript{69} The consent provisions of the federal regulations require that the patient’s waiver of confidentiality be in writing. This written form must identify the patient, the treatment provider, and the recipient of information. In addition, it must contain a statement of the purpose for the proposed disclosure, a description of the precise information to be communicated, an identification of the date, event, or condition upon which the consent will expire, and a statement that the consent is subject to revocation at any time unless the program has already acted in reliance on it. See § 2.31.
\end{itemize}
referral activities constitute the provision of diagnosis or treatment of a kind contemplated by those laws and regulations. If the answer to this question is yes, a host of potential obligations have to be met to insure compliance with the law. The federal regulations contain explicit requirements with respect to maintaining the security of patient records, and severely limit access to them. Unless information that is "patient-identifying" (in the sense that it communicates facts relating to an individual's diagnosis, referral or treatment for a AOD disorder) is either segregated physically or electronically, these rules would strictly limit the ability of medical staff and others within the hospital to review the patient's chart or discuss the patient's status and ongoing treatment. In addition, the restrictions on disclosure would limit what medical personnel could say to a patient's family, friends, or work colleagues. Moreover, these limitations generally are rigorously enforced, and their violation carries potential civil and criminal penalties.

Clearly, under the original HEW regulations promulgated in the 1970s the answer to the question, whether emergency departments and trauma centers undertaking AOD screening and intervention activities would be subject to the federal AOD confidentiality regulations, would have been in the affirmative, given that the term "program" was broadly defined to include any entity "which, in whole or in part, holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment," and given that the term "patient" was taken to include any person who had applied for or received an interview, counseling, or other related service by a program, even if the individual had never been admitted for treatment and even if the program deemed that he or she was not in need of such services. In 1987, however, at the urging of hospitals and others concerned about the administrative burdens resulting from this broad application of the federal AOD confidentiality law, HHS revised the confidentiality regulations to exempt general health-care facilities such as hospitals and community mental health centers from the federal AOD confidentiality law's obligations. Even under the 1987 revisions, though, specialized AOD treatment units and individuals within general health care facilities such as hospitals and CMHCs

70 See § 2.16.
71 §§ 2.12(a), 2.13(a)(b).
72 See § 2.4.
were still covered, if these units or individuals were identified as providing diagnosis, referral, or other treatment services for substance use disorders.\textsuperscript{75}

This was the state of the law in 1989, when the United States Court of Appeals for the Ninth Circuit decided \textit{United States v. Eide}.\textsuperscript{76} \textit{Eide} involved the prosecution of a pharmacist for diverting controlled substances. The defendant had been treated at a hospital emergency room for substance abuse, and information relating to that emergency room care had been made available as evidence in the criminal case against him. On appeal, Eide argued that this information was subject to the federal AOD confidentiality law and regulations and that no exception in the law and regulations permitted its disclosure in this instance. A majority of the Ninth Circuit panel agreed with Eide, concluding that: (1) he was a “patient” within the meaning of the federal regulations; (2) the emergency room was a “program,” and (3) the lab results and statements Eide made to medical personnel in the emergency room were protected “records.”\textsuperscript{77}

Under the 1987 amendments to the AOD confidentiality regulations, an individual or other federally supported entity was still a covered “program” if it held itself out “in whole or in part” as providing “alcohol or drug abuse diagnosis, treatment, or referral for treatment.”\textsuperscript{78} In the context of a hospital or other “general care facility,” however, the 1987 amendments additionally required that the provider either be an “identified unit” which provides AOD services or “medical personnel or staff whose primary function” is the provision of such services.\textsuperscript{79} The question in \textit{Eide} was how to interpret these rules given that the hospital emergency department in that case regularly “perform[ed] functions unrelated to drug abuse” as well as functions clearly falling within the definition of alcohol and other drug diagnosis, treatment, and referral for treatment.\textsuperscript{80} In concluding that the emergency room’s multiple functions did not exempt it from the federal confidentiality rules, the Ninth Circuit relied on the “in whole or in part” language in the first part of the definition and concluded that because the emergency room was a “vital first link” in the diagnosis, referral, and treatment of substance abuse patients, some of whom

\textsuperscript{75} 42 C.F.R. § 2.11 (1987) (defining the term “program”).
\textsuperscript{76} 875 F.2d 1429 (9th Cir. 1989).
\textsuperscript{77} \textit{Id.} at 1435-36.
\textsuperscript{78} § 2.11.
\textsuperscript{79} \textit{Id.}
\textsuperscript{80} 875 F.2d at 1436.
ultimately ended up in a specialized treatment unit in the hospital, it was an “identified unit” for purposes of the federal law. The Substance Abuse and Mental Health Services Administration (“SAMHSA”) proposed further amendments to the regulations. In its Notice of Proposed Rulemaking, SAMHSA pointed out that the 1987 amendments had been intended to exclude non-specialized units within general hospitals, presumably including most emergency departments, on the theory that including such entities did not serve Congress’s expressed purpose of:

enhanc[ing] treatment incentives for alcohol and drug abuse, since many substance abuse patients are treated in a general medical care facility not because they have made a decision to seek substance abuse treatment, but because they have suffered a trauma or have an acute condition with a primary diagnosis of something other than substance abuse.

The SAMHSA regulators proposed a restructured definition of the term “program” in the hope, only partially realized, that this restructuring would clarify the issue that had been raised in Eide.

The revised regulatory language, which is the currently applicable provision, deleted the “in whole or in part” language and reworked the previous definition by organizing it into a three-part disjunctive test. The first prong is limited explicitly to individuals and groups “other
than a general medical care facility” who hold themselves out as providing AOD-related services. The second and third prongs then take up the instance of AOD treatment providers operating within a general hospital or other general health-care facility. Prong two includes as a regulated program “an identified unit” within such an institution if it “holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.” Notably, this second prong still does not address explicitly the question of how to categorize an identified unit that holds itself out as providing both AOD diagnosis and treatment as well as other non-AOD related services. The third prong, by contrast, does directly deal with this problem of multiple functions. It provides that “medical personnel or other staff” in a general hospital or other general care facility are regulated as a “program” under the federal regulations if their “primary function” is the provision of AOD services and they are “identified as such providers.” Thus, even after the promulgation and adoption of these most recent amendments to section 2.11’s definition of a “program,” we are still left with linguistic ambiguity regarding how to treat hospital emergency departments and trauma centers whose “primary function” is not to provide AOD services, but who hold themselves out as providing those services as part of a broader array of emergency health-care functions.
Notwithstanding this lacuna in the regulatory language, SAMHSA sought to provide guidance to emergency departments in its 1994 Notice on confidentiality coverage. Specifically, the regulators indicated that, while individuals with an AOD treatment specialization working in an emergency room or trauma center would be covered by the federal regulations only if their primary function was AOD treatment, the emergency room "as a whole" would be covered so long as it had "promoted itself to the community as providing such services."\(^8\)

The amended language of the regulations together with this promulgation history was further interpreted by the United States Court of Appeals for the Tenth Circuit in \textit{Center for Legal Advocacy v. Earnest}.\(^9\) In \textit{Earnest}, a Tenth Circuit panel reversed a District Court decision that had followed \textit{Eide}, on the grounds that the District Court's opinion had been superseded by the subsequent amendments to the federal regulations.\(^1\) Even with the new three-part definition of "program," the Tenth Circuit panel still had some work to do to support its conclusion that the AOD regulations did not apply to the hospital emergency room in this case. The issue arose following the death of a patient who had been treated in the hospital's emergency department and then transferred to its intensive care unit. The patient's death was being investigated by the plaintiff, which had been statutorily mandated to "investigate incidents of abuse and neglect of individuals with mental illness."\(^2\) The hospital had resisted the plaintiff's efforts to obtain information about the deceased's emergency department care, on the grounds that that information was protected by the federal AOD confidentiality law and regulations.\(^3\)

Directing its attention initially to the third prong of the new definition, the court concluded that nothing in the record supported a finding available to patients exhibiting signs of intoxication. What is less clear is whether the EMTALA requirement that patients receive a MSE provides a legal basis for arguing that other emergency department patients should receive AOD screening services as well. If that interpretation were adopted, of course, there would be an even stronger claim of holding out.


\(^{90}\) 320 F.3d 1107, 1111-12 (10th Cir. 2003).

\(^{91}\) \textit{Id.} at 1110-11, 1112.

\(^{92}\) \textit{Id.} at 1109. The plaintiff in this case had been designated a protection and advocacy organization under the federal protection and advocacy system. This system, which is a creation of federal law, directs designated organizations to "investigate incidents of abuse and neglect of individuals with [disabilities] and to take appropriate action to protect and advocate the rights of such individuals." \textit{Id.} (quoting Iowa Prot. and Advocacy Servs. v. Gerard Treatment Programs, 152 F. Supp. 2d 1157 (N.D. Iowa 2001)).

\(^{93}\) \textit{Id.} at 1109.
ing that individuals on the medical staff in the emergency room were “primarily” providing AOD treatment services. The court relied upon deposition testimony of the associate director of emergency medicine at the hospital that “the emergency room personnel . . . [were] not identified specifically as licensed alcohol or drug abuse treatment providers or counselors.” In addition, the court noted that the nurse who had provided the individual patient with care stated in his deposition that he “was not a provider of alcohol abuse treatment but rather a trauma nurse.”

The Tenth Circuit panel also concluded that the emergency department of the hospital did not meet the requirements set out in the second prong of the regulations’ definition of a “program.” The court had to address the arguments of the hospital and of the District Court that the emergency department was an “identified unit,” because it had a close working relationship with a specialized AOD treatment unit within the hospital. Faced with “significant evidence of integration” between the hospital’s emergency room and its specialized treatment unit for chronic substance use disorders, the Tenth Circuit panel focused instead on questions of licensure and public relations.

With respect to licensure, the court pointed out that hospital administrators had testified in deposition that neither the emergency department itself nor any individual medical staff members within the emergency room were licensed to provide ongoing care for chronic AOD disorders. With respect to public relations, the court relied on the fact that the emergency department had been marketed as providing a full range of emergency services but had not specifically held itself out as providing AOD-related services.

It is becoming increasingly difficult to argue, however, that many hospital emergency departments and trauma centers do not hold themselves out as providing alcohol and other drug diagnosis, counseling, and referral services as a regular component of the health care they

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94 Id. at 1111-12.
95 Id.
96 Id.
97 Id. at 1112.
98 Id.
99 Id.
100 Id. (“While Dr. Cantrill testified that the emergency department holds itself out as being a fully staffed emergency department and that drug and alcohol abuse often includes medical emergencies, he admitted that the emergency department made no claim that it provided any ongoing care for “[t]he more chronic components of chronic alcohol or chronic drug abuse . . . .” [T]he Hospital had never made significant efforts to market the emergency room as part of its drug and alcohol abuse treatment program.”).
provide. At least in the case of Level I and II trauma centers, this type of “holding out” is inherent in the requirements for COT certification, and in the broad push that leaders within the field have made to advance the idea that AOD screening and intervention is and ought to be an integral part of trauma care.\textsuperscript{101}

In addition, as more emergency departments and trauma centers offer these services, the likelihood increases that patients with drug and alcohol problems will be seen on the unit by individuals whose “primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.”\textsuperscript{102} While the patient in the Earnest case had not been treated by a licensed alcohol or drug abuse treatment provider or counselor, in other emergency department or trauma center settings, even if an initial screening can be accomplished by personnel without specialized AOD training, the more intensive assessment of patients who screen positive may require the involvement of an AOD specialist.\textsuperscript{103} Similarly, the emergency department in Earnest had a “close working relationship” with a specialized AOD unit in the same hospital and could have relied on staff of that unit to provide this sort of support.\textsuperscript{104} In other settings, the trauma center or emergency department may have an AOD specialist on staff or may arrange for a number of staff members to be trained to conduct AOD screenings and interventions.\textsuperscript{105} To some extent, these staffing decisions involve important policy choices by hospital administrators and others about how best to balance the goals of mainstreaming or integrating AOD diagnosis and treatment on the one hand, and protecting the confidentiality of individual patients’ drug and alcohol abuse information on the other.\textsuperscript{106}

Taking into consideration all of the foregoing, we can now begin to organize an analysis around the elements of the federal AOD confidentiality regulations. As we have seen, in order for the regulations’ limitation on the disclosure of information to apply, either the entire unit or some identified individual or individuals within the unit would have to be determined to be a “program,” and the information would have to relate to a “patient,” defined by the regulations as someone

\textsuperscript{101} See supra text accompanying notes 13-21.

\textsuperscript{102} 42 C.F.R. § 2.11 (2008) (see part (c) of the definition of “program”).

\textsuperscript{103} See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 4.

\textsuperscript{104} Earnest, 320 F.3d at 1110, 1112.

\textsuperscript{105} See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 1.

\textsuperscript{106} See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 6.
who has received AOD screening, assessment, intervention and/or referral services. Putting aside for the moment the specific facts of any given case, it may be possible to use standard tools of statutory (or in this case regulatory) interpretation to help determine whether, and under what circumstances, the federal confidentiality regulations apply to the provision of AOD services by emergency departments and trauma centers. On one side, proponents of applying AOD confidentiality regulations in this setting could make a relatively straightforward argument based upon the language and structure of the federal regulations. This argument would center on the observation that only the third of the three prongs making up the definition of “program” in section 2.11 contains an explicit “primary function” requirement. Given that the three prongs are linked with the disjunctive term “or,” which means that each represents an alternative basis for finding that an entity is covered, it is reasonable to conclude that an emergency department or trauma center need not have as its primary function the provision of AOD services, so long as it otherwise meets the requirements of the second prong of the definition contained in section 2.11 (i.e., that it “holds itself out” as providing and does provide AOD services, along with a wide range of other medical services).

In response, opponents to treating trauma centers and emergency departments as covered “programs” would likely build an argument on SAMSHA’s observation that “many substance abuse patients are treated in a general medical care facility not because they have made a decision to seek substance abuse treatment, but because they have suffered a trauma or have an acute condition with a primary diagnosis of something other than substance abuse.” Thus, from this perspective, the protections of the federal AOD confidentiality regulations are unnecessary because concerns about the stigma associated with substance abuse treatment are unlikely to dissuade patients from seeking emergency or trauma care.

This purposive argument, while compelling, is not necessarily conclusive, given the dual purposes served by the AOD confidentiali-

107 See 42 C.F.R. §§ 2.11-2.13; see also State v. Johnson, 163 Ohio App. 3d 132, 2005-Ohio-4243, 836 N.E.2d 1243, ¶ 37-41 (narrowly interpreting the term “records” as it relates to “identity, diagnosis, prognosis, or treatment of any patient” in the federal confidentiality regulations); Mitchell v. Mt. Hood Meadows Oreg., 99 P.3d 748, 754 (Or. Ct. App. 2004) (concluding substance use information did not constitute a “diagnosis” and therefore was not the basis of a prohibited disclosure of treatment records).

108 42 C.F.R. § 2.11.

ty laws and regulations. In addition to creating a generalized perception among potential patients that it is safe to seek substance abuse treatment, the federal scheme also aims to protect individual patients from the concrete harms that disclosure of their substance use disorders could cause. Thus, even if a given patient who has suffered injuries in an automobile accident or who has suffered an acute medical emergency would be unlikely to avoid emergency care because of the lack of AOD confidentiality protections in the emergency room, harms could still flow to that individual if a positive alcohol or drug screen or assessment were disclosed to family, friends, insurers or employers.

Under section 2.11, a “patient” is “any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse” by a covered program. Section 2.12(c)(1) states that the regulations “cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program,” and section 2.12(e)(4) provides that the regulations protect “any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse.” Here again, as with the regulations’ definition of “program,” considerable uncertainty exists about how to handle screening and assessment information indicating that a patient has a substance use disorder, particularly if that information has been gathered by emergency or trauma center staff both for purposes of the medical management of the patient’s acute injuries or illness and also as part of a universal screening and intervention policy.

Some commentators who have considered whether the AOD confidentiality regulations should apply to emergency departments and trauma centers have suggested that the answer should turn on the reason why information about a patient’s alcohol or other drug use has been gathered. Thus, a consensus panel of experts convened by the Center for Substance Abuse Treatment has advised that if alcohol screening is undertaken:

110 See supra text accompanying note 7.
112 42 C.F.R. § 2.11.
113 § 2.12(e)(1), (4).
114 The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS), promotes the quality and availability of community-based substance abuse treatment services for individuals and families who need them. See Ctr. for Substance Abuse Treatment, U.S. Dep’t of Health & Human Servs., http://csat.samhsa.gov/ (last visited May 3, 2010).
to effect the management of the presenting condition, it is protected by general rules about patient confidentiality and need not be treated differently from any other medical information. To gain a complete and accurate clinical picture, a physician needs access to all of a patient’s records concerning history and present condition. Such information should include whether there is an underlying pattern of substance abuse, since this information may have a bearing on the patient’s condition. AOD screening may be done in order to identify antecedent problems or conditions that may have an impact on the medical management of the patient’s presenting condition. This information, then, gathered for the purpose of managing the present condition, would not be subject to the Federal regulations.\textsuperscript{115}

While this approach clarifies the situation when AOD screening is conducted \emph{solely} for purposes of medical management, it does not provide guidance about whether an emergency department or trauma center patient becomes an AOD “patient” for purposes of the federal regulations when the information has been obtained \emph{both} to treat the presenting condition and as part of a broad program of AOD screening and intervention. Indeed AOD information, including laboratory screens and other diagnostic tests and assessments, may be generated both for the purpose of medically managing the presenting condition and for the purpose of identifying patients with substance use disorders in order to provide them interventions at a moment when this sort of counseling may be most effective. Here, then, as with the regulatory definition of “program,” the problem of multiple functions appears not to be clearly resolved by either the language or the structure of the federal regulations, taken on their own terms.

This failure of the federal AOD confidentiality regulations to resolve clearly the problem of multiple functions likely results from the fact that the treatment of most AOD patients in the United States has historically been provided by separate, specialized clinicians.\textsuperscript{116} Thus, regulatory language restricting the application of the federal regulations to an “identified unit within a general medical facility” or to personnel whose “primary function is the provision of alcohol or drug abuse” treatment\textsuperscript{117} reflects the reasonable assumption that medical personnel whose primary responsibilities involve the provision of

\textsuperscript{115} See CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., \textit{supra} note 25, at ch. 6.

\textsuperscript{116} See \textit{supra} note 6 and accompanying text.

\textsuperscript{117} 42 C.F.R. § 2.11.
non-AOD related health-care services do not regularly provide substance abuse diagnosis or treatment as well.

Moreover, the gap in the law also stems from the fact that the federal regulations are built around a conception of alcohol and other drug problems that diverges from the operating premise of the new movement to offer screening, assessment, intervention, and referral services broadly in emergency departments and trauma centers. Thus, the AOD regulations reflect a “dispositional disease model,”\(^{118}\) that has dominated thinking about substance use disorders since at least the middle of the twentieth century. In the case of alcohol use, this model dichotomizes the population into a small set of persons who are “alcoholics” and a much larger group for whom the ingestion of alcohol is not dangerous. The key difference between these two groups is that alcoholics are thought to have an “abnormal, constitutional disposition influenced by enduring biological factors” that causes them to lose control over their drinking behavior.\(^{119}\) According to this “disease model” of alcoholism, the disease, “although incurable, can be suppressed through abstinence.”\(^{120}\)

Although the dispositional disease model has stimulated the development of effective treatment for persons with alcohol dependence, it has not addressed the significant harms that non-dependent problem drinkers can suffer.\(^{121}\) An important premise behind the screening and intervention approach, by contrast, is that not all substance abusers fall within the “dispositional disease model,” but instead can be located across a continuum marked at one end by persons who are alcohol dependent and at the other end by persons who are either risky drinkers or who engage in problem drinking.\(^{122}\) It is, in part, in order to advance the health interests of this much larger group of problem drinkers that screening, assessment, and intervention strategies have been developed for emergency department and trauma center settings.

As recognized by the Institute of Medicine in its 1990 report *Broadening the Base of Treatment for Alcohol Problems*, acceptance

\(^{118}\) Hungerford, *supra* note 6, at S10-11.

\(^{119}\) *Id.*

\(^{120}\) *Id.* at S10.

\(^{121}\) See *Id.* at S11; *see also* Saitz, *supra* note 9.

\(^{122}\) For a discussion of this new paradigm for thinking about the range of problems associated with alcohol consumption, see Saitz, *supra* note 9. While the chemical properties of drugs other than alcohol vary, as do the precise physical effects of their ingestion, the idea that the problems of misuse fall out along a continuum from severe chemical dependency at one end to the risks of occasional use at the other remains a useful construct for thinking about the development of regulatory and public health policy.
of the dispositional disease model has led to the development in the United States of a specialist AOD treatment system focused on alcoholics and other addicts that is not well suited to meeting the needs of patients who may suffer from mild-to-moderate problems with substances of abuse. Because this latter group is much larger than the population targeted by the specialist AOD treatment system, it probably accounts for a correspondingly higher percentage of the AOD-related injuries seen in emergency departments and trauma centers. Consequently, the idea of providing a general regime of screening, assessment, and intervention services in these settings has taken hold as a means of preventing a broader range of diseases and injuries related to substance abuse.

Importantly, the regime of screening and intervention activities contemplated by this new paradigm is systematic and not an incidental feature of the care offered by the emergency departments and trauma centers that have adopted this approach. It is in this respect specifically that the assumptions behind the federal AOD confidentiality regulations fail to square with the new and developing public health oriented practice of emergency and trauma center staff. In its 1994 Notice of Proposed Rulemaking relating to the AOD confidentiality regulations, HHS explained that:

these regulations do not apply to alcohol or drug abuse prevention programs, whether based in general care facilities or otherwise, which do not hold themselves out to the community as providing alcohol or drug abuse diagnosis, treatment or referral for treatment, even though such programs may occasionally refer individuals to treatment for substance abuse as an incidental function of the prevention program.

In addition, HHS stated that “although the regulations would not ordinarily apply to a staff physician of an emergency room or an intensive care unit who refers an overdose patient to a drug abuse treatment practitioner, they would apply to a drug abuse treatment practitioner whose primary function is to provide such services.” What both of these statements fail to recognize is that, regardless of whether there is an explicit “holding out,” staff physicians and others in emergency

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123 See Comm. on Treatment of Alcohol Problems, INST. OF MED., supra note 11, at 84-86.
124 See Gentilello et al., supra note 3, at 1253-54.
126 Id.
and trauma settings increasingly are screening for and intervening with patients who have alcohol and other drug problems, not on an occasional or exceptional basis, but systematically and as a regular feature of their clinical practices. Some of these patients will be identified as alcohol or drug dependent and in need of specialist AOD treatment, others will be assessed as problem or risky users who may benefit from a brief intervention or other counseling services linked closely to the immediate circumstances of the particular patient’s hospital admission. In either case, the treatment professionals will have obtained information relating to the patient’s abuse of alcohol or other drugs, information that could be harmful to the individual if disclosed. In light of the systematic nature of this diagnostic, counseling, and referral activity, and in light of the potential harms that disclosure could produce, the better approach may be to regard these screening and intervention programs as covered by the AOD confidentiality regulations.

III. OPERATIONALIZING THE FEDERAL CONFIDENTIALITY LAW AND REGULATIONS IN THE CONTEXT OF EMERGENCY DEPARTMENTS AND TRAUMA CENTERS

Once the federal confidentiality regulations are deemed to apply to emergency department and trauma center screening and intervention activities, a second-order question is whether the regulations should cover the entire unit as the “program” or whether individual AOD specialists (if they are employed on the unit) should be designated as the “program.” If the latter approach were adopted, the restrictive disclosure requirements of the federal regulations would not apply to all the staff members on the unit in their communications of information about patients who receive screening and intervention services, although the AOD specialist or specialists would be prohibited from disclosing patient-identifying information to their non-specialist colleagues. In contrast, if the entire unit were regarded as

127 See supra notes 29-42 and accompanying text.
128 See Field et al., supra note 41, at S24-25.
129 See generally Gentilello et al., supra note 3, at 1251-52 (discussing the legal parameters of disclosing a patient’s alcohol or drug use disorder to other health care professionals within the same treatment facility).
130 For purposes of the federal AOD confidentiality laws and regulations, a disclosure is “patient identifying” if it identifies an individual as a recipient of alcohol or other drug diagnosis, treatment, or referral services. See supra text accompanying note 63.
the “program,” then the more demanding federal AOD regulations necessarily would play a role in shaping the information management practices of all staff members of the emergency department or trauma center. Even in this circumstance, however, only information identifying the patient as having received AOD diagnosis, treatment, or referral for treatment would be subject to the regulations’ restrictions on disclosure. Thus, information limited to the patient’s receipt of other health-care services would not be subject to the more robust requirements of the federal AOD regulations.\textsuperscript{131}

In settings where the entire unit is treated as the “program” for these purposes, AOD information could be segregated physically or electronically in separate files, in order to prompt staff not to share this information with colleagues within the program in circumstances in which its communication would not be necessary in order to support the treatment of the patient’s AOD problem, and to prevent its communication to others outside the program as well.\textsuperscript{132} In units where some (but not all) of the individual staff members are designated as the “program,” the need for segregated record-keeping systems would be even more urgent, because the specialist staff members would not be able to rely on the internal program communication exception contained in the regulations in order to share information with others providing care to the patient on the unit.\textsuperscript{133}

The internal program communication exception is one of at least three ways that the federal confidentiality regulations would permit the sharing of patient-identifying information by an emergency department or trauma center that is designated a “program.” As noted above, a communication of information that is patient identifying is not a prohibited disclosure under the regulations if it takes place


\textsuperscript{132} CTR. FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 25, at ch. 7; Gentilello et al., supra note 3, at 1253-54. Given the stigma associated with drug use disorders, even the disclosure of information about a patient’s addiction and treatment to other health care providers can present risks to the patient. Thus, one published article reports that:

[the] director of training and recovery services for the National Association of Medication Assisted Recovery, has been told by the physician in charge of his treatment that he should not tell other doctors that he’s on methadone, but rather should have them contact the opioid treatment program (Beth Israel Medical Center). ‘What happens is as soon as they hear you’re a methadone patient, they assume you’re drug seeking and you don’t get good treatment,’ he said.

\textit{Battle Lines Drawn over Patient Confidentiality Issues,} ALCOHOLISM DRUG ABUSE WEEKLY, Mar. 8, 2010, at 1, 1, 3.

\textsuperscript{133} 42 C.F.R. § 2.12(c)(3).
“within the program” (i.e., between program staff) and is undertaken in connection with the recipient’s duties in the provision of alcohol or other drug treatment services. Employing this exception, a trauma surgeon or other staff member could share information about a patient’s substance abuse with a colleague in order to assist in the recipient’s performance of an AOD assessment, in order to facilitate an AOD intervention or referral, or to further any other activity fairly regarded as the provision of AOD diagnosis or treatment. On the other hand, a communication of patient-identifying information from one staff member to another for purposes of providing health-care services not directly related to the diagnosis or treatment of a patient’s alcohol or other drug use disorder would not qualify for the internal program communication exception and would be prohibited by the federal AOD regulations, unless another exception to the general prohibition on disclosure applied.

For disclosures outside the “program,” the federal AOD regulations permit the use of what are termed “qualified service organization agreements” (QSOA). Under the regulations, an outside entity that provides one or more of a wide range of services (e.g., laboratory, billing, legal, and other medical services) to an AOD treatment program may receive patient-identifying information without obtaining individual patient consent, if the outside service provider enters into a written agreement under which it agrees to abide by all of the requirements of the confidentiality regulations as if it were a covered program. In effect, the QSOA provision brings the outside service provider within the treatment program for these purposes, thus making the sharing of patient-identifying information an internal program communication and not a prohibited disclosure. While longstanding HHS interpretations have maintained that two AOD treatment programs may not enter into a QSOA arrangement with one another, it is clear that an AOD treatment program may communicate patient-identifying information pursuant to a QSOA with an outside health-care provider who is furnishing primary medical services

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134 Id.
135 § 2.12(c)(4).
136 Id.
137 Id.
138 See, e.g., U.S. DEP’T OF HEALTH AND HUMAN SERVICES, PUB. HEALTH SERVICE, OFFICE OF THE GEN. COUNSEL, LEGAL OPINIONS ON THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS 1975-1978, at 79 (1980). For example, a detoxification facility and a long-term follow-up care facility may not enter into a QSOA with one another to facilitate patient referrals. See id.
to the AOD program’s patients in a fashion that supports the underlying alcohol and other drug treatment.\textsuperscript{139} Depending on the particular circumstances, QSOAs could conceivably be executed in order to permit the sharing of otherwise confidential information between staff members of an emergency department or trauma center covered by the federal AOD regulations and other non-AOD health-care professionals.

Finally, the federal regulations permit the disclosure of information identifying a patient as the recipient of AOD diagnosis, treatment or referral services, if the patient provides proper written consent.\textsuperscript{140} The regulations are unusually detailed in setting out the elements of an effective patient consent form. The form must contain the name of the patient, the treatment program, and the recipient of the information. In addition, the consent form must contain a statement of the purpose for the proposed disclosure, a description of the precise information to be communicated, an identification of the “date, event, or condition upon which the consent will expire,” and a statement that the consent is subject to revocation by the patient at any time unless the program has already acted in reliance on it.\textsuperscript{141}

While patients who are conscious and competent at the time of their admission to an emergency department or trauma center could be asked to execute a written consent form at that time, the logic of the consent provisions suggests that programs should not seek broad, open-ended permission to share AOD information.\textsuperscript{142} Moreover, given the circumstances and nature of the presenting conditions typical of patients in these units, many patients will not be conscious or competent upon admission. The federal regulations do not permit family members, friends, or others responsible for a patient to give consent on his or her behalf, unless the third party is the patient’s legal guardian, and no explicit provision is made for substitute consent (for most purposes) in the case of a medical emergency.\textsuperscript{143} Thus, although

\textsuperscript{139} See LEGAL ACTION CTR., CONFIDENTIALITY: A GUIDE TO THE FEDERAL DRUG & ALCOHOL CONFIDENTIALITY LAW AND HIPAA 35 (2006).
\textsuperscript{140} See 42 C.F.R. § 2.31.
\textsuperscript{141} Id.; see also Boldt, A Study in Regulatory Method, supra note 49, at 2333 (describing the required criteria for effective written consent).
\textsuperscript{142} 42 C.F.R. § 2.31. This is because the structure of the consent provisions contemplates that individual consent forms will be executed by patients in light of the stated purpose for the disclosure that is being permitted.
\textsuperscript{143} In the case of a patient who has been adjudicated incompetent by a court, consent to disclose patient-identifying information may be given by the patient’s lawfully appointed guardian or legal representative. § 2.15(a)(1). If the director of the program determines that a patient’s medical condition prevents “knowing or effective action on his or her own behalf,” but there has been no adjudication of incom-
some patients may be in a position to give consent at a later point, the consent provisions of the regulations are unlikely to be a complete solution to the problem of authorizing the disclosure of confidential information in the course of emergency department or trauma center staff undertaking assessment, intervention and referral services.

In the final analysis, notwithstanding these significant limitations in the AOD regulations, because HIPAA has altered the default environment for hospitals more generally with respect to patient privacy and information management, the administrative inconvenience of requiring segregated record-keeping may not be as great as one might at first think. Under HIPAA's Privacy Rule, health care professionals and administrators are required to employ different standards depending upon whether a proposed communication of patient information is intended for third-party payers, family members or others with an obligation of care, other health care providers, and the like. A clear interrelationship exists between the federal standards for AOD information, the federal HIPAA standards, and the various state law patient privacy standards that hospitals must meet. The question is whether upset ency, the program director may authorize a disclosure without patient consent, but only for the purpose of obtaining reimbursement from a third-party payer. § 2.15(a)(2).

With respect to the issue of a potential conflict between the two federal health privacy schemes under consideration—the HIPAA Privacy Rule and the federal AOD confidentiality regulations—it is important to move beyond the question of which is more stringent, to a determination instead, as HHS stated in the preamble to the proposed Privacy Rule, of whether a conflict exists. The separate question of which of several provisions is more stringent is meant to apply primarily to conflicts between federal and state law. In determining whether two federal provisions are in conflict, the HHS preamble directs attention to whether the relevant provisions are permissive or mandatory. Thus, if one provision is permissive (e.g., HIPAA's approach to the disclosure of patient information without individual written permission for payment purposes) while the other is mandatory (e.g., the AOD regulations' requirement of written patient consent), then there is no conflict because the mandatory requirements of the latter scheme would necessarily apply. Thus, HHS explained that:

the first principle that applies where both the HIPAA standards and implementation specifications and the requirements of another federal program apply is that we must seek to reconcile and accommodate any apparently conflicting federal requirements. Two conclusions flow from this principle. First, where one federal statute or regulation permits an activity that another federal statute or regulation requires, and both statutes apply to the entity in question, there is no conflict, because it is possible to comply with both sets of federal requirements. Second, where one federal statute or regulation permits, but does not require, an activity that another federal statute or regulation prohibits, there is again no conflict, because it is possible to comply with both sets of federal requirements.
policymakers should drop to the lowest common denominator (often HIPAA), in order to minimize or avoid the administrability costs associated with maintaining separate standards, or whether the benefits to patients derived from a more complex legal regime are worth the effort. This is a difficult empirical question that researchers have not squarely addressed.\footnote{146}

As the foregoing discussion suggests, the federal AOD law and regulations can plausibly be read either as applying to emergency department and trauma center screening and intervention programs, or not. Fundamentally, this indeterminacy is due to the failure of the drafters of these provisions to foresee that AOD problems do not occur bi-modally, as the dispositional disease model presumes, but instead fall out along a broader continuum. Framed in this way, the precise question is whether diagnosis and counseling functions directed at individuals in the middle of the continuum and at the less severe end should be regarded as covered AOD “treatment.”

Perhaps it is worth considering the adoption of a limited use exception in the context of patient confidentiality rules governing AOD treatment within emergency departments and trauma centers.\footnote{147} Such


\footnote{It is worth noting, however, that HHS's position that the AOD regulations should not apply to general medical facilities, other than specialized units, was driven by considerations of administrative expense and inconvenience. Thus, in Congressional testimony about the proposed regulations, the regulators explained that “[a]pplicability to specialized programs will lessen the adverse economic impact of the current regulations on a substantial number of facilities which provide alcohol and drug abuse care only as an incident to the provision of general medical care.” Confidentiality of Alcohol and Drug Abuse Patient Records, 52 Fed. Reg. 21796, 21797 (June 9, 1987) (to be codified at 42 C.F.R. pt. 2).

\footnote{On February 5, 2010, a proposal of this sort was released by a group calling itself the “Patient Protection Coalition.” This group, which is led by Professor Richard J. Bonnie of the University of Virginia School of Law and Dr. Eric Goplerud of George Washington University, proposed amending the federal AOD confidentiality law and regulations to:

- permit[] very limited disclosures of information about substance use disorder treatment to health care providers and health plans for purposes of treatment, coordination of care, recovery support, quality improvement, disease management and payment. Disclosures allowed by the proposal are much more restricted than those allowed by the HIPAA Privacy Rule. Further, the only items that can be disclosed without authorization for these two limited exceptions are demographic information, diagnosis, medications, laboratory results, and identification of past or current treatment providers.

Richard Bonnie et al., Patient Protection Coalition, A Proposal to Promote Coordination of Care and to Strengthen Patient Protections Under the Federal Alcohol and Drug Abuse Confidentiality Law (2010),
an exception has been created within the federal AOD laws and regulations to permit treatment programs to comply with state child abuse reporting requirements (at least with respect to an initial report, if not as to follow-up investigations by departments of social services). \(^{148}\) Other such exceptions have been considered and rejected in the past, and new exceptions should be carefully scrutinized and limited. This is particularly the case because once opened up, there would be considerable political pressure\(^ {149}\) to create rules permitting disclosures to criminal justice system officials. \(^ {150}\) In the case of communicable disease reporting (including HIV), the AOD treatment community has managed to make state law disclosure regimes work within the existing provisions of the federal confidentiality regulations. \(^ {151}\) Thus, taken as a whole, the history in this area suggests that considerable circumspection is called for before significant amendments are undertaken.\(^ {152}\)

http://www.law.virginia.edu/pdf/faculty/bonnie_patientprotection.pdf (on file with author); see also Battle Lines Drawn over Patient Confidentiality Issues, supra note 132, at 1.

\(^ {148}\) Section 2.12(c)(6) of the federal AOD confidentiality regulations provides that:

The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

42 C.F.R. §§ 2.12(c)(6); see also supra text accompanying note 67.

\(^ {149}\) Concern about this risk has been raised by AOD treatment advocates, including groups like Faces and Voices of Recovery, and the Legal Action Center. See also Battle Lines Drawn over Patient Confidentiality Issues, supra note 132, at 1. The latter group has explained that "[a]mending the underlying statute would create great — and we strongly believe unacceptable — risk that bedrock protections could be eviscerated during the legislative process." See LEGAL ACTION CTR., CONFIDENTIALITY OF ALCOHOL AND DRUG RECORDS IN THE 21ST CENTURY (2010), http://www.privatepractice.org/ConfidentialityofAlcohol.pdf.

\(^ {150}\) It is important to remember that treatment for ongoing drug abuse is different than treatment for other diseases, including other mental illnesses, because of the legal jeopardy that attaches to the possession of a controlled substance.

\(^ {151}\) AOD treatment providers can comply with state HIV reporting and tracking requirements without violating the federal confidentiality regulations by obtaining patient consent or using qualified service organization agreements. In addition, it often is possible to communicate relevant information without disclosing the patient's AOD status, thus preventing the communication from being a prohibited "disclosure" under the federal regulations.

\(^ {152}\) For a good example of this sort of circumspection, see J. Zoe Beckerman et al., Cal. Healthcare Found., Mar. 2008, http://www.chcf.org/-/media/Files/PDF/A/ADelicateBalanceBehavioralHealthAndPrivacyB.pdf. A variation of this paper, by
CONCLUSION

As the foregoing discussion suggests, the existing provisions in the federal law and regulations governing the confidentiality of alcohol and other drug use treatment were not written with the new screening and intervention activities of emergency departments and trauma centers in mind. In other contexts, however, these provisions adequately accommodate the interests of patients and of the AOD treatment system on the one hand and satisfy concerns relating to administrative convenience and expense on the other. The rules dealing with patient consent, internal program communications, and QSOAs represent sensible judgments in this area of public policy. Of course, they presume an AOD treatment system that is not well integrated into the broader health-care delivery system, and that is to be regretted. Notwithstanding the inhibiting effect that the federal AOD confidentiality rules may have on future efforts toward mainstreaming addictions services, however, the fact remains that the dangers of untoward disclosure of this patient information are still very real. Accordingly, it would be premature to progress far down the road of statutory or regulatory amendments in anticipation of an integrated system that does not yet exist, so long as that legal jeopardy persists.

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153 These other contexts include, at a minimum, situations in which the sharing of information is required in order to support research, audit and evaluation functions, to facilitate program funding and administration, to coordinate care with other mental health and general health care providers, and to encourage clients’ job training and employment activities.