

Balancing Confidentiality Concerns with Quality Coordinated Services for the SPMI and Dually Diagnosed Client

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Balancing Confidentiality Concerns with Quality Coordinated Services for the SPMI and Dually Diagnosed Client

Abstract. The author addresses the many misconceptions about the rules and role of confidentiality that exist within and between both the substance abuse and mental health delivery systems in New York State. Additionally, the article discusses the similarities and differences between substance abuse and mental health rules regarding confidentiality as it applies to professional communications. The author explores both legal and ethical codes and guidelines to describe a delivery system where optimal protection of the client's confidentiality and maximum professional communications can occur within and between the discussed service systems. The author has included forms and instructions on how to set up the legal networks, releases and informed consent necessary to establish a respectful and efficient delivery system

Introduction. Basic to all human service professional practice is efficient and effective communications: communications with the clients we are trying to help, our coworkers and supervisors, other service professionals, and finally, the communities and families that we serve. Without effective and efficient communications our clients will not get the help that they need, our coworkers and collateral professionals will be uninformed and uninvolved, and the communities and families that we serve will be wondering what it is that we are doing for them. Communications between human service professionals and each of these groups goes through different channels, with each channel governed by formal and informal rules. The purpose of this Section is to explore and clarify the channels that are available to professional human service providers in New York State, particularly those in the mental health and substance abuse delivery systems. Understanding the limits of professional communications is essential for a human service delivery system to function efficiently and effectively. Usually, when human service professionals are asked a general question about how to improve the service delivery system they invariably state, “Better communications within programs and between programs.” This paper will elucidate how to establish more effective communications systems within your delivery system.

Suggestions made in this article are based upon both legal documents and ethical guidelines that are influential in determining the legal and common practices of human service practitioners. Despite the fact that these documents have not changed much in the past few decades, few delivery systems have taken full advantage of them to better serve their clients. The result has been that human service workers have been following their *program culture beliefs* about the limits of professional communications rather than being guided by the legal and ethical standards. The balance between effective professional communications and confidentiality concerns has been weighted heavily towards confidentiality concerns, which has negatively impacted case coordination, and at times relationships between provider agencies.

Effective and efficient professional communications becomes even more paramount in communities whose resources are low in density, such as rural and semi rural counties. These communities, if they have many small stand-alone services, need to have very fluid communications between them in order to even remotely approach the level of coordination of services afforded within larger full service agencies in larger communities. Additionally, persons who present with multiple needs, like the dually diagnosed and seriously and persistently mentally ill (SPMI), also present a challenge to agencies to communicate very efficiently and effectively. Communities that do not maximize their capacity to communicate quickly and clearly about these challenging clients are risking both the health of the client and the costs that might be associated with over-utilization of more acute care services. Effective professional communications promote proactive treatment rather than crisis driven treatment. The benefit of effective and efficient communications to the recipients of our services is self-evident.

History and legal basis. Although history of the development of the concept of confidentiality is beyond the scope of this paper a few points will help frame the current

discussion. It should be no surprise that mental health and substance abuse confidentiality laws developed somewhat independently and have a different source of legality. Mental health issues have a long history of state and local involvement, especially in New York. New York State first codified law relating to the mentally ill with the Insanity Laws of 1896. The current code is the Mental Hygiene Law of 1972 as amended and subsequent case law. Thus, most legal guidelines in New York State regarding confidentiality between professionals is based upon New York State Mental Hygiene Law and related case law.

Substance abuse services developed somewhat divorced from mental health services, due to stigma, failure of the predominate mental health treatment models in treating substance abuse, and finally the emphasis upon self-help. Possibly due to the high stigma of substance abuse and lack of response by states to an increasing problem, the federal government stepped into regulate the field. 1972 marked the first federal enactment of laws governing confidentiality of alcohol and drug abuse treatment information. Interestingly, laws almost identical were enacted separately for alcohol and other substance abuse. They were amended in 1986 to comply with state mandated child abuse statutes reporting and then finally consolidated in 1992 into a single federal confidentiality law covering both alcohol and drug abuse records and information. The U.S. Department of Health and Human Services issued regulations in 1975 to implement these laws which are found in the Code of Federal Regulations (CFR) Title 42, Part 2. (Legal Action Center, 2000)

Confidentiality of mental health treatment information. Article 33.13 Section 33.13 (a)-(f), of the New York State Mental Hygiene Law delineates the conditions and to whom mental health information can be transferred. Additionally it limits the amount of information, stipulates that a stated purpose must accompany the disclosure, and restricts disclosure to minimum amount of information necessary for the stated purpose.

Release to non-professionals. Section 33.13(c)(7) details the professional exchange of privileged client information and includes only one provision available for the release to non-professionals, who are defined for purposes of this paper as individuals who are not treatment providers or are outside the classes of individuals covered by an exception to disclosure. Section 33.13 (c)(7) provides the only legal basis for disclosure of clinical information to non-professionals; like friends, family members, or insurance companies, it states; “with the consent of the patient or client or of someone authorized to act on the patient’s or client’s behalf, to persons and entities who have a demonstrable need for such information and who have obtained such consent, provided that disclosure will not reasonably be expected to be detrimental to the patient, client or another provided, however, that release of such information to a patient or client shall not be governed by this subdivision.” It should be noted that although it is common practice to obtain a *written* release the NYS-MHL does not require such, it does make good sense from a risk management point of view.

The implications of Section 33.13 (c) (7) is in order for non-professionals to get or receive information, including identification, about a client from a treatment provider the

non-professional must meet the following conditions: demonstrable need for the disclosed information, consent from the patient (usually written), and that disclosure would “not be reasonably expected to be detrimental to the patient,” and finally that any received information remains protected under confidentiality law. These conditions are very restrictive and historically often frustrates family members of the mentally ill as they attempt to ascertain the whereabouts, condition, and care of their loved ones¹. It is the author’s speculation that the restrictive tone of communications with non-professionals has been generally misapplied to professional communications, thus creating an environment where effective collaboration when sought by one party becomes resisted by the other. The intent of confidentiality clearly is to protect the patient’s privacy and autonomy, not restrict professional efforts to supply quality services.

Professional communications of mental health information. Section 33.13 of the NYS-MHL details the many circumstances where professional and emergency communications is allowed, and in most cases without consent. These situations are summarized in the following sections all refer to Section 33.13(c)(1-13).

1. Pursuant to a court order where a determination has weighed confidentiality against interests of justice.
2. To mental hygiene legal services.
3. To attorneys representing clients in proceedings involving involuntary hospitalization.
4. To the commission on quality of care for the mentally disabled or their agents.
5. To a medical review board of the state commission of corrections in respect to a death of a patient or if the patient requests the information.
6. To an endangered individual and law enforcement when it has been determined that a patient or client presents a serious and imminent danger to that individual, such as child abuse or neglect.
7. With consent of the patient or authorized agent of the patient. (See above)
8. To the state board of professional medical conduct or office of professional discipline, and their agents while performing their legal obligations.
9. With consent of the appropriate state commissioner in a number of situations not limited to: authorizing third party payers, qualified researchers, when necessary to prevent harm to a client or other, or to a district attorney investigating alleged abuse of a patient.
10. To a correctional facility consistent with various NYS corrections laws.
11. To a qualified person pursuant to Section 33.16, essentially the legal guardian of an incompetent person.
12. To the local Director of Community Services or his designee in the performance of statutory duties.
13. To the State Division of Criminal Justice for the sole purposes of providing care or providing access to care.

¹ Coppola, Joseph R., “Communications, compassion key to working with families.” (Opinion statement) *OMH Quarterly*, September 2000.

Professional communications within the local services plan. The above lists very specific exceptions of prohibitive disclosure of confidential information in professional and emergency communications, generally in light of some statutory duty of the recipient of the confidential information. In contrast, Section 33.13 Sub Sections D-F delineates the limits of professional communications during the course professional of *clinical* duties. Sections D-F are clearly intended to facilitate cooperation between members of the service delivery system in order to provide care. The recipients of confidential information through any of the provisions in the following sections are bound to maintain the information as confidential and are not to redistribute without consent of the client.

Section 33.13(d) explains that limitations on confidentiality in Section 33.13 are *not* to “prevent electronic or other exchange of information concerning patients or clients, including identification, between and among” the following: 1) facilities or others providing services for patients pursuant to an *approved local service plan* or unified services plan, as defined by Section 41 of the NYS-MHL or pursuant to agreement with the department [of Mental Health], 2) the department and or any of its licensed or operated facilities. Additionally, this Section provides opportunity for the Commissioner of Mental Health to allow release of information to licensed hospital emergency services.

Section 33.13(e) adds to the above by adding that records exchanged through any of the legal mechanisms above are not to be made a public record and are afforded the same legal protection of confidentiality once received. Additionally, Section 33.13, Section F charges that the information that is released pursuant to any section of this Section, “be limited to that information necessary in light of the reason for disclosure” Hence when a professional finds it necessary to release information under any section of this Section it needs to be assessed in terms of being the least amount of information for the purposes intended.

Section 33.13(d), (e), (f), are the basis of regular professional communications within a local service plan between providers who are working with or planning for the care of clients in their charge. It should be noted that none of these sections require consent or informed release of information (Although, as discussed later, some professional ethical codes require such and most agency policy requires some sort of informed consent.) These sections simply require the recipients to treat the disclosed information with all the limitations of confidentiality as if the information were produced by their own clinical activities.

Section 33.13(d), (e), (f), are the most radical departure to many public service delivery systems current *program culture* conceptualization of the limitations of confidentiality. Furthermore, any private practice clinician might be aghast at the level of fluidity of privileged information afforded to agencies within the local service plan. The current effort in this section has been to describe the *absolute legal limits of confidentiality* as described by the NYS-MHL, within which clinicians, patients, and the local service agencies are free to construct acceptable practices. It is the author’s contention that mental health service delivery systems are not taking advantage of the limits of confidentiality as described by the NYS-MHL and are thus missing out on opportunities

to coordinate and collaborate their services, especially in respect to the difficult to treat, dually diagnosed and SPMI clients. Conversely, it might be the case in some situations that inaccurate *program cultural beliefs* of confidentiality give license to avoiding engagement with difficult to treat clients.

Confidentiality of alcohol and other drug treatment information. Rules that regulate the confidentiality of alcohol and other drug (AOD) information are enumerated in Title 42 of the Code of Federal Regulations (CFR) Part Two. Further references to the CFR in this paper should be interpreted as applying to the aforementioned Title. The CFR applies to any program, or part of a program, which specializes in the treatment of AOD problems and that receives federal assistance by any means: directly, as in payment for services, or indirectly, such as under IRS non-profit status. The CFR supercedes any state laws (Section 2.20) that are less restrictive of AOD confidential information; thus setting a national legal standard. The following sections of this paper will explore relevant issues of confidentiality as they relate to professional communications and case coordination: 1) the limits and exceptions of AOD communications, 2) communications with non-professionals, 3) communications with professionals.

AOD information restrictions and limitations. Section 2.12 states that, “restrictions on disclosure in these regulation (the CFR) apply to any information whether on not it was recorded which... would identify a patient as an alcohol or drug abuser either directly, by reference or other publicly available information.” Note that the CFR uses the notion of any identifying information of an AOD user as the minimal benchmark for violation of confidentiality, realizing that disclosure of personal treatment information requires at *least* individual identification. Violation of the CFR is a federal crime, with possible criminal penalties in the form of fines.

Communications with non-professionals. The one exception to the CFR confidentiality rules that permits communications with non-professionals, by written release is under Section 2.3 of the CFR. For the purposes of this paper, the term non-professional refers to individuals who are not treatment providers or are outside the classes of individuals covered by an exception to disclosure. The written release must contain elements described in Section 2.31, which will be discussed later in this paper. The CFR states that even if the releasing program is uneasy with whom the information is being released the release must take place. The CFR places the patient as the final arbitrator of signed, written releases. It should always be assumed that a completed release, signed by the patient is a valid authorization for release of information. A signed release is not, however, a compulsion for information to be released. Additionally, the client may revoke any release without cause at any time. One exception to revocation is special releases for criminal justice system cases. Although beyond the scope of this paper, when constructed correctly, a patient who signs a release of information as a condition of criminal court (not family court) involvement is not allowed to revoke the release except as specified in the particular release, Section 2.35 (c). In summary, all communications between non-professionals and professional AOD staff need to be based upon full consent with a written and signed release.

Exceptions to the general prohibition of AOD release of information. The following is a listing of the exceptions to CFR prohibition of releasing identifying patient information as described in CFR Title, 42 Part 2. Subparts C, D, E. Three basic categories apply: disclosures with consent, disclosures without consent, and disclosures by authorizing court order. It should be noted that under Section 2.3(b), “these regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exist under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure, but it does not compel disclosure.” Thus, the discretion to disclose remains the decision of the clinician making the disclosure.

1. By written consent of the individual.
2. Release in response to special *authorizing court orders* following Sections 2.63-2.67 of the CFR. Subpoenas and warrants are not adequate under the CFR.
3. Communications outside a program where no patient identifying information is being released, such as statistical information.
4. To medical emergency workers: information relevant for life saving treatment.
5. Obligations under state child abuse reporting regulations; *not* for abuse of other groups of persons like elderly or disabled even if mandated by state law.
6. Release of identity to law enforcement when a crime has been committed against the program or personnel by a patient.
7. Research, audits and program evaluations by qualified personnel.
8. Through internal program communications.
9. Release of information to an agency covered under a qualified service organization agreement (QSOA)

Professional communications of AOD information. Professional communications of AOD information for the purposes of treatment coordination and case management are possible under three of the above mentioned exceptions to disclosure: the internal program communications exception, the qualified service organization agreement exception, and of course by written client consent. Any AOD information that is disclosed by any method, electronically, verbally, or written, two conditions need to be followed by the recipient of the disclosed AOD information: 1) they are obligated to not re-disclose the information without a new consent, 2) they must resist any criminal justice attempts to acquire the protected information without an authorized court order as mentioned above.

Written consent for disclosure. Obviously, written consent gives the professional the greatest amount of sanctioned authority to work with confidential information with respect to care coordination and clinical collaboration. Written consent is the choice method of exchange of clinical information and the only one that allows professional communications with family members. Additionally, not only does the CFR allow consent for a two-way disclosure between the patient’s AOD program and one other party, but also the patient may sign a multi-agency release to consent. All the agencies need to comply with CFR rules about non-redisclosure and to resist court orders. However, the consent *must* contain the certain items in order to be in compliance with Section 2.31 of the CFR, which is covered in more depth later in this paper.

Written consent obviously assumes that the patient knows about the communication and probably the details of the disclosure as required in the consent form. Two other exceptions to disclosure of AOD under the CFR, do not *require* that the patient be informed about professional communications that occur on their behalf. This is not to say that they should not be *informed* about such communications as a general practice or ethical or clinical duty. That said, the professional needs to be aware of the legal *capacity* to communicate information through these channels in the event that clinical or ethical judgement dictates that would be in the interests of good client care. These two exceptions to disclosure which are relevant to professional clinical communications are: internal program communications and agencies under a qualified services organization agreement.

Internal program communications allows all professionals under single direct administrative control to exchange protected information for the purposes of treatment and other related clinical duties. Basically, this allows an AOD clinical staff to have clinical discussions about their clients among themselves on a need to know basis. The concept of ‘program under direct administrative control’ can be an inexact conceptualization, e.g. what if the AOD program is part of a general hospital? The rule about the limits of internal program communications exception under CFR Section C, (3) limits disclosure to that information necessary to allow a staff person to perform their professional duties.

The internal program communications exception allows for full, part-time, and unpaid volunteers to all be considered part of the AOD program. Thus, an outside professional that becomes part of the AOD’s program in order to assist in treatment meetings, as an unpaid consultant, is considered to be part of the program. All aspects would then bind this person of the CFR restrictions on further disclosure. For example, the consultant would not be able to go back to a home program and enter this information into his or her clinical record without utilizing one of the other exceptions to disclosure, like a signed release or a QSOA. Another example that would utilize the internal program communications exception would be if a mental health and substance abuse clinic were run by the same agency. These distinct units if under the same direct administrative control would be able to exchange information relevant to treatment and client care. No formal legal entities are necessary for internal program communications to occur. Only the definition of a ‘program under direct administrative control’ needs to be met.

Qualified service organization agreement (QSOA). A QSOA is a written agreement between two agencies. AOD programs may find it useful to enter into QSOA’s with various agencies in order to facilitate coordinated care and provide their patients ready access to other agency services. Under Section 2.12, C(4) of the CFR an AOD program *may* disclose information to a QSOA without the patient’s consent. Once again, the previous statement simply addresses the statutory limits of the QSOA exception to disclosure. The statute does not address what would be ethical and clinically responsible or effective treatment in any given situation. A ‘service organization’ is able to provide services to the AOD program such as: data processing, dosage preparation, lab work,

voc-rehab services, legal advice, accounting services, or other related necessary professional services. Other services can include but are not limited to: mental health evaluation, outpatient mental health treatment, inpatient mental health treatment, emergency room services, housing services, case management services or primary health care. Service organizations that enter into written QSOAs with AOD programs must agree to the following two conditions:

1. Acknowledges that in receiving, storing, processing or otherwise dealing with information from the AOD program about patients, it is fully bound by the confidentiality regulations in the CFR, e.g., like non-redisclosure.
2. Promises to resist, in judicial proceedings if necessary, any efforts to obtain access to information pertaining to patients except as permitted by CFR regulation.(LAS, 2000)

The QSOA allows each party to the agreement to exchange necessary information for the 'service organization' to deliver a service, such as housing or mental health care to the patient of the AOD program. QSOAs have been implemented between a variety of organizations to provide better care and services for AOD patients: welfare services, child welfare services, public health services (like treating and tracking infectious disease) and of course mental health services. There are two types of organizations that are not allowed to enter into a QSOA with an AOD program: another AOD program or law enforcement organizations. A limitation to the usefulness of the QSOA as a tool for enhancing client care is that only two agencies can enter into the agreement, multi-agency agreements are not allowed. Another limitation is has to do with the QSOA's provision that the information-receiving agency may not re-disclose patient identifying information. This would require that received information be kept distinct in the client record, so that it does not get re-disclosed. Despite these limitations QSOAs will no doubt contribute to a more efficient and effective delivery of care and services for many AOD patients. A sample QSOA contract can be found in the appendix.

Evaluation of professional ethical codes. Developing a new framework for the analysis of the ethical debate over confidentiality concerns and the client's access to quality coordinated care is beyond the scope of this paper. The alternative to a more abstract discussion is to evaluate the codified results of professional association's ethical discussions. The ethical codes of National Association of Social Workers, The American Psychological Association, and the American Medical Association's Principles of Medical Ethics for Psychiatrists were all evaluated as a representative sample of ethical frameworks for human service professionals. These professional association are known to have shaped the delivery of human services, especially behavioral services and no doubt have a common interest in the delivery of respectful, efficient and high quality care.

Many human service professionals are familiar with these ethics codes, perhaps having read them once for a graduate class, read parts of them in textbooks, or even occasionally referred to them. All of the ethics codes are on-line for reference and links are provided in the reference section of this paper. Most human service professionals would likely guess that professional ethics codes are *more* restrictive than legal codes, when it comes

to confidentiality. This turns out to *not* be the case. Each of the evaluated ethical codes sampled were generally, less precise and more liberal when it came to the conditions of disclosure, usually deferring to program policy, or legal statutes. Generally, the ethical codes were more concerned about the client being informed about the limits of confidentiality and the process of treatment itself. Upon reflection this makes sense, since legal statutes are really just codified representation of ethical constructs.

The sampled ethical codes, when compared to the NYS-MHL and to the CFR, did produce some similarities and differences worth noting. Examination of these is necessary if we are going to be successful in elucidating how to create a delivery system that maximizes the opportunity for delivery system collaboration within both ethical and legal frameworks. Each of the sampled professional ethical codes will be explored in the sections below.

American Psychiatric Association. Section 4 of the APA Principles of Medical Ethics states, “A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safe guard patient confidences within constraints of the law.” Two points of law discussed in the above sections are included in this ethical code: confidentiality as it applies to the patient, and to other professionals. This ethical statement upholds the import of confidentiality rights that the patient has, but also understands that the confidences of other professionals who interact with the psychiatrist, thus implying a protection against re-disclosure. Section 4, Subsection 1 reiterates the importance of confidentiality down to the level of patient identification, which is very much the theme of the CFR. This subsection also implores the physician to be “circumspect about the information that he/she chooses to disclose to others about a patient” combined with Subsection 5 which states, the psychiatrist may disclose only that information which is relevant to the given situation” and avoid speculation, which is a principle described in both the NYS-MHL and the CFR: minimal information necessary for the purpose of the release.

Section 4, Subsection 2 states” A psychiatrist may release confidential information only with the authorization of the patient or under the proper legal compulsion.” Defines that patient authorization is a primary principle. Written authorization is not required by the ethics code. It should be assumed that federal, state laws and program policy would dictate the requirement for written authorization. Obviously, documenting permission with the patient’s signature would be most judicious, but not always possible in the dispatching of care. Additionally Subsection 2 requires that the physician fully appraise the patient of the connotations of waving [any portion] of the privilege of privacy. Again, this implies the notion spelled out legally as informed consent. Subsection 8 deals with emergency care where the safety of the community or the patient is at imminent danger; this situation releases the physician to disclose necessary privileged information. This ethical statement allows physician compliance with various state laws, which require disclosure in the event of a child or other community member being at risk of harm. Subsection 9 requires that physician explore any court order as to the risk to treatment that release may bring to the client. It is implied that the physician resists the order, and raises to the court the need for any protected information. The CFR and NYS-MHL

require at least this level of court resistance. In summary, the APA Principles of Ethics require careful balancing of patient confidentiality, patient interests, informed release, and respect for the legal statutes related to release of privileged information down to the level of identification.

American Psychological Association. The psychologist's Ethical Principles cover a lot of territory due to their very wide purview as professionals in the human services. Under Standard 4.01, Structuring the Relationship, psychologists contribute a concept that has not been directly codified in this paper thus far, but alluded to in the legal code: early disclosure of the conditions and limitations of the therapeutic relationship. Standard 4.01 states, "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship appropriate issues, such as the nature and anticipated course of therapy, fees, and confidentiality." Additionally, psychologists reinforce the concept of informed consent where the therapeutic procedure and other limitations are discussed in terms that the client can understand.

Standard 5 is concerned more directly with the privacy and confidentiality concerns. Standard 5.01 re-emphasizes that the psychologist discusses with the client, as soon as feasible, the relevant limits of confidentiality. Additionally, psychologists are expected to take "reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional relationships." Similar to legal and other ethical standards it is also expected that the psychologist only release "information germane to the purpose for which the communication is made, (5.03a)" and that "information only be shared for professional purposes and only with persons clearly concerned with such matters", that effect the client. (5.03b). "Psychologists are allowed to disclose information without consent of the individual only as mandated by law *or where permitted by law* for a valid purpose such as, 1) to provide needed professional services to the patient, 2) to obtain appropriate professional consultations, 3) protect the patient or others from harm, 4) to obtain payment." (5.05a)

National Association of Social Workers. The NASW Code of Ethics has been reevaluated a number of times over the years. This current draft was approved in 1999. Social workers practice in the widest variety of context and thus, their ethic's code reflects a more generalist tone. The following summarizes the relevant portions to the current discussion on professional communications. Under Ethical Standard 1.03 the code visits the concept of informed consent. This standard emphasizes that consent to services needs to be explained in terms that the client can understand, the limits of the services, the extent that services can be refused, and the time frame covered by the consent. Social workers are also asked to elicit questions from the client about the consent and its implications.

Standard 1.07 and the various subsections are very important to the current discussion of professional communications. The limitations of disclosure are to be discussed by the social worker with the client. In a variation on the minimal disclosure principle, social workers should only elicit the minimal amount of information of the client such as

necessary to perform the service, once this information is disclosed by the client then the standards of confidentiality apply. (1.07a) Of course, disclosure may be released by social workers with valid consent, although the ethics guidelines do not compel the social worker to have a written consent. Social workers are charged to protect confidentiality for all client information except for compelling professional reasons. Included in this exception to strict disclosure are to prevent harm to the client or others. Social workers are asked to whenever possible inform the client of the disclosure beforehand, and what the consequences of the disclosure might be, regardless of the basis for the disclosure. (1.07d) Additionally, disclosure to court actions are like with the NYS-MHL, and CFR, other ethical frameworks, to be resisted by the social worker, and the minimal information rule to be followed.

Construction of efficient and effective professional communications. The next sections will be concerned about using the legal and ethical frameworks described above and formulating them into a system that provides the maximum opportunity for professionals to communicate effectively to deliver coordinated care. The challenge is to describe a communications system that is not too complex for anyone to use. What will be described is a distilling process, where the legal maximum is attainable, and no ethical lines are crossed by any human service professional. The balancing act is between confidentiality concerns and providing quality coordinated care to the client, which as mentioned earlier is of great importance to the effective clinical management of the dually diagnosed and the SPMI client. Without effective and efficient communications systems in place these client will no doubt suffer more than necessary.

There are two basic components to effective maximum implementation of the legal and ethical systems described above: *organizational components* and *client interface components*. Together these parts will make a delivery system able to communicate effectively within and between its parts. It will not create an environment that any professional can talk to any other professional at any time for any reason. It will, however, create professional communications pathways while protecting the client's privacy and delivering quality coordinated care.

Organizational components to professional communications. These are the parts of the professional communications system that allow *agencies* to communicate with each other. Informed consent will be assumed to have occurred at some point earlier in treatment and that will be covered under client interface components. On the mental health side, the organizational component is the local service plan (LSP), under Section 33.13 Sections D-F of the NYS-MHL, which allows members to communicate about shared clients for the purpose of coordinated treatment. On the AOD side of the treatment system the use of the Qualified Service Organization Agreements (QSOAs) exception to disclosure needs to be utilized between all agencies providing services to the AOD program. QSOAs allow communications over objection and without written consent to occur between the two agencies within the agreement for the purposes of enhancing and coordinating care. Again, assume that informed consent to treatment has already occurred. Each of these organizational professional communication components will be discussed below.

Organizational components: mental health. The existence of the mental health local service plan exception to prohibited disclosure needs to be communicated and understood by each mental health agency in the LSP. The mechanism most likely is through some coordinating group of mental health system administrators or simply through a memorandum of understanding that is acknowledged by all providers. Legally, this allows uninformed and over-objection communications to any other LSP provider. However, professional ethical concerns limit the full utilization of this in all but the most compelling or legally required circumstances. Additionally, most ethical systems sampled above have a general requirement that the client be informed of the nature and purpose of the information being disclosed, even if it is over objection. This ethical duty must take place even if it is determined that the communication has to occur over objection. It would be expected that this situation will be very rare, but the prepared clinician will now have an option to enhance client care in these strenuous situations.

An example might be, a client tells a mental health housing social worker that he just overdosed, inspection proves that his medications are not around. He has a history of serious overdoses in the past. The client then says he did not really take the medications and states that he does not want the social worker to call his doctor. The social worker is worried and has an intuitive feeling that the overdose occurred. Under the LSP the social worker can call and inform the doctor of the situation after informing the client that this communication will happen. Under common notions of confidentiality, the social worker without direct proof of imminent danger could not proceed with the communications over objections. The social worker saves the day, by utilizing the limits of professional confidentiality via the LSP.

Organizational components: AOD. AOD treatment providers should survey with what other professional organizations do their clients receive care from regularly, especially emergency care. After that assessment, the AOD organization should enter into QSOAs with each of these agencies. This would require signed contracts that explicitly define the limits of the disclosures between the two agencies as described in the CFR. Examples of worthwhile QSOAs might include: DSS, emergency room services, mental health services, health department. These QSOAs should be made explicit to the clients upon admission to the AOD program, perhaps with a signed service agreement and perhaps crossed out if not appropriate for any particular client. A sample QSOA contract is included in this paper's appendix and in the Legal Action Center book on confidentiality referenced by this paper. (LAC, 2000)

An example of an effective use of a QSOA might be as follows: an AOD client shows up at the ER of a local hospital on the weekend. She has been drinking after just a few weeks of treatment at the local alcohol outpatient center. She says that she wants to enter treatment and is afraid to wait till Monday, then takes off. The ER nurse, who is aware of the QSOA with the outpatient treatment provider, contacts the on-call person, who is able to help the ER nurse develop a plan for the possible return of this person to the ER. The outpatient provider is better prepared to treat this person upon return to their care given that the client's drinking has resumed. The effectiveness of outpatient treatment and the

ER intervention is enhanced by the QSOA and the ER nurse's knowledge of it. Outreach to such a client might prove to be very effective and improve retention in treatment and outcomes.

Client interface components: informed consent and the service agreement.

Complete legal and ethical obligations to the client can not be met without informed consent about the treatment, the methods of treatment, the limits of confidentiality, and methods of recourse to a client, and permission to notify a significant other in case of physical or mental health emergencies. Additionally, any rules governing the conduct of the *client* while in treatment, like 24 hour notification, are all best provided up front to the client as soon as feasible. The principle of early information about informed consent and treatment expectations are codified in a number of ethical guidelines, and can also act to familiarize the client with the culture of being in treatment, but also ally any questions in a direct manner. Most clinical service providers have these documents upon entry as a formality they may have to be modified to increase their usefulness as a tool for better professional communications. These documents are the front door of the coordinated service delivery system.

Every service provider within a local service area should take care during the service agreement process to inform the client of the existence of the LSP and any QSOAs. The clinician describing the informed consent/service agreement should take care to help the client understand that only minimal, necessary information will ever be communicated, and that in most cases the client will be notified or have signed a release of information. In cases where interagency communication is likely, the clinician presenting the service agreement needs to communicate to the client the need for coordinated care such as that made possible by the collateral professional communications. Obviously, having the client sign a multi-agency release of information (ROI) would most directly communicate to the client to whom information may be disclosed. Informed consent during intake has the advantage of covering unexpected situations where disclosure may be necessary for enhancing treatment. An informed consent/service agreement form needs to contain the following information: a listing of the agency's professional obligations to the client, a listing of the expectations that the agency has for the client's participation in treatment, a listing of the limits of confidentiality including existence of LSP and any QSOA, description of grievance procedures. An example of an informed consent/service agreement and a multi agency release of information are available in the appendix of this paper.

Client interface components: release of information (ROI). The ideal method of professional communication involves a collaborative relationship with your client, who understands the need for case coordination and sanctions it through a signed release. The ROI thus, is the most clinically desired method for case coordination and should be offered and encouraged by any clinician who has a need to collaborate with other professionals on behalf of their client's care. The clinician may have to overcome their own biases about the limits of confidentiality to sell the ROI to the client. The best methods need to be explored and perfected by each clinician, but generally it will involve the establishment of a trusting relationship between the client and the clinician. The

client needs to have full trust that the clinician will protect private communications and only communicate those facts necessary to enhance case coordination or client care. Additional to the ROI, the clinician might have an explicit conversation about the needed information and run any issues by the client who might think are too exposing for the situation.

The service delivery system that works together regularly, as in a smaller community, should develop a release that meets the standards of both the NYS-MHL and the CFR. Additionally, the ROI should have the option of releasing information to multiple agencies. Listed below are the minimal elements that must appear upon the ROI in order to be compliant with the NYS-MHL *and* the CFR and ethical codes sampled by this paper. An example of such an ROI can be found in the appendix of this paper:

1. General designation of the program making the disclosure.
2. Individual or organization(s) that will receive the disclosure.
3. Name of patient who is the subject of the disclosure.
4. Purpose or need for the disclosure.
5. How much and what kind of information will be disclosed.
6. A statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it.
7. The date, event, or condition upon which the consent expires if not revoked.
8. A reference to the legal statues that the release is formulated upon.
9. Statement about the irrevocable nature of a criminal justice release for substance abuse services.
10. A statement about prohibition on redisclosure of confidential information under Title 42, Part 2 of the CFR and Section 33.13 of the NYS-MHL.
11. A statement that revocation of the ROI does not terminate legally obligated communications (like child abuse reporting), communications with LSP providers, or QSOAs.
12. Signature of the patient.
13. Date which the consent was signed.

Summary of findings. Professional communications between direct practice providers of services, between and within the two major disability groups of substance abuse and mental health are paramount for the successful treatment of the SPMI and dually diagnosed individual. Collaborative efforts for the treatment of individuals so afflicted constitutes a best practice model. Conversely, lack of collaborative and coordinated care will no doubt result in poor outcome and needless suffering. Presented in this paper are the legal and ethical frameworks and their implications for the development of a maximally open professional communications system. Given these tools to communicate in a professionally responsible fashion it is left to the professionals, programs and delivery systems at large to decide how to use and implement these tools. It is hoped that *program culture beliefs* about the limits of confidentiality have been challenged by the information in this paper and expanded so that more efficient and effective treatment can be dispatched.

Appendix Contents

1. Best practice suggestions for professional communications
2. Template of consumer informed consent and service agreement
3. Template of CFR/NYS-MHL complaint multi-agency release of information (ROI)
4. Template of a QSOA agreement

NOTE: The content of the document and the appendices is designed to adhere to the New York State Mental Hygiene Law. Treatment providers in other states should consult their particular state law(s) in order to make necessary modifications to these guidelines.

Best practice suggestions for professional communications

- Programs within a delivery system develop a similar informed consent/service agreement that describes the limits of communication and elucidates the need for professional communications. Additionally, it would explain the relationship requirements of the provider and the consumer of services. This document needs to be compliant to both CFR and NYS-MHL and introduced early in the course of treatment.
- Programs within a delivery system develop a similar multi-agency release of information form and the clinicians in the programs take care to explain and advocate that necessary ROIs are signed early in treatment. This document needs to respect CFR, NYS-MHL and ethical codes in its execution.
- Programs within a delivery system enter into QSOA's as necessary and reaffirm their right to coordinate care under the local service plan provision in the NYS-MHL.
- Professionals are informed about the limits of professional communications to the most maximum legal and ethical limits.
- Professionals be taught and practice the rule of minimum disclosure for purpose of coordination.
- Professionals routinely document any information shared with collateral as part of the clinical record, documenting the communication pathway that the information was released through. For example, by signed release, via a QSOA, via the LSP etc.
- Professionals develop the skills necessary to explain the need for professional communications to their clients. Additionally, develop a routine where any communications necessary for the coordination care is discussed with the client before hand.
- Professionals understand the CFR and NYS-MHL's prohibition on the redistribution of clinical information without further consent.
- Professionals have thorough grasp of the emergency exceptions to prohibited disclosure as described in the CFR and are willing to practice them without hesitation or deliberation.
- Professionals have an understanding of the resistance to court orders as mandated by law in the CFR and the NYS-MHL. The CFR requires a very high standard for disclosure to a court: an authorizing court order is necessary, not just a subpoena.
- Professionals all read, and understand their respective ethical guidelines and the relationship between the guidelines, the law, and clinical efficacy.
- Professionals understand that information about clients within the framework of confidential protection under the law are protected down to the level of patient identification.

Template of a Consumer Informed Consent and Service Agreement

Welcome to Our Agency. We will do our best to help you. There are a few things that we would like you to know right at the beginning of your relationship with Our Clinic. Going over this service agreement will provide you with information that will help you use our service better. Please direct any questions about this service agreement to your intake worker.

Clinic's Responsibility to You

- We will provide you with treatment for your specific problem, we are licensed to provide (list services), but will help you get care for any other problems that we are not able to treat here. We will work with you to coordinate our treatment with care you get elsewhere.
- We will inform you if we believe that your need for treatment exceeds our ability to help you or if we believe that you are not in need of our level of care. We will assist you in getting the correct level of care and work with you and the referral to make any transitions a positive experience.
- We will supply you with a treatment environment that assists you in your efforts to help yourself. On that order, Our Clinic staff will be timely for your appointments, respect your privacy, make reasonable accommodations if you have a disability that makes getting our service difficult, respect your decision to stop treatment, and provide you with recourse if you have a complaint about our service without fear of reprisal.
- We will not re-disclose any information that we receive from your prior treatment providers without your expressed consent and we will resist any court order attempting to obtain information about your records.
- We also follow the New York State Office of Mental Health Rights of Outpatients that is posted at every licensed site. It contains your rights as a consumer and whom you can contact if you feel you are not being treated fairly.
- List any other responsibilities that Your Agency might have towards the client's care.

Your responsibility to Our Clinic

- While in treatment you will be expected to participate in planning your treatment and following through. You may be asked to do homework, participate in groups, and sign release of information, if indicated for your treatment.
- While in treatment you will be expected to communicate any changes you experience that directly effect your treatment plan to your clinician, so that your treatment can be adjusted to the changes. For example, if you are being treated for depression and you

start to have suicidal thought we expect you to notify you clinician or other staff. Another example would be if you are getting substance abuse treatment and you relapsed over the weekend. Your clinician needs to know so that we can help you.

- While in treatment you are expected pay any fees or make arrangement to have the fees paid by a third party. You will be expected to work with your clinician on questions regarding your insurance or managed care company.
- While in treatment you are expected to cancel any appointments 24 hours in advance. Our Clinic reserves the right to charge you for missed appointments not so canceled. It would be your responsibility to obtain a follow up appointment from your clinician if you cancel.
- List any other client responsibilities Your Agency might have.

Limits of Confidentiality

Our Clinic closely adheres to New York State Mental Hygiene Law (Section 33.13) and to Federal Guidelines regarding confidentiality of substance abuse information (Title 42, Part 2 of the CFR). Disclosures that you make during your treatment are confidential as defined by the above laws.

There are some exceptions to confidentiality that we want you to be aware, some of the exceptions are for emergency situations, and some are agreements we have with other agencies to better coordinate care. It is our clinician's ethical obligation to discuss with you any information that is shared with other professionals, except in emergencies. It is also our ethical and legal obligation to disclose only the minimal amount of information relevant for the purpose it is sought for.

- We are allowed to disclose information when you sign a release of information. The information will be limited to what you and your clinician decide to be appropriate for the situation. This is the only method for Our Clinic to release information to a family member.
- We are allowed or required to disclose information under various legal compulsions such as: when child abuse or neglect has occurred, when New York State Mental Hygiene Legal Services request information, to attorneys challenging involuntary hospitalization, to the NYS Commission on Quality of Care or its representatives, to NYS Board for Professional Medical Conduct, to the local director of mental hygiene, or when we receive an authorizing court order from a judge (which is more difficult to get than a subpoena). All these situations tend to be very rare.
- We are ethically and legally obligated to disclose *only* relevant information in the event of various emergency situations: if we believe that you or another person in the community may be at risk to serious harm we are allowed to inform authorities. This only includes levels of harm that are viewed as possibly life threatening. We are not

allowed to disclose information to anyone but the appropriate authorities or medical personnel. (Substance abuse agencies under the CFR can only disclose information to medical personnel for life threatening situations. Under the CFR there currently is no explicit 'duty to warn' provision, which trumps NYSMHL. Non-identifying tips to authorities are possible, if ethical considerations supercede the legal limits)

- We are allowed to disclose information if a crime has been committed on the premises or against program personnel. We will only disclose information to the authorities and only the minimal amount necessary for law enforcement to conduct their duties.
- We are allowed to disclose information with other providers who are involved or are planning to be involved in your care. We have special agreements with these agencies that have agreed to use the same high standards to keep your information confidential that we use. Most likely, you will have authorized any disclosure to other providers by Our Clinic. We have relationships with the following organizations: (List QSOAs and LSP agencies)
- We are not permitted to contact family members in the event of an emergency. You however, can authorize Our Clinic to do so by filling out this emergency form. We will only use this in the event of an emergency.

Name of Emergency Contact: _____
 Relationship to contact: _____
 Address of Contact: _____
 Home Phone: _____
 Work Phone: _____
 Special Instructions: _____

Thank you for reading this service agreement. Please direct any questions about this service agreement to your clinician. Please sign and date this form confirming that you have read this agreement.

Signature

Date

Template of CFR/NYS-MHL compliant multi-agency release of information

This document authorizes Our Agency to release information to the party(s) listed for the purposes described. The recipients of the confidential information are legally obligated under Title 42, Part 2 of the Code of Federal Regulations (Substance Abuse) and under NYS-MHL Section 33.13 (Mental Health) to maintain the information confidential, are restricted from re-disclosure without further written consent from you unless otherwise permitted under law. You may revoke this consent at any time unless action has been taken in reliance upon it already. Our Agency may be liable for Federal and/or State fines and/or criminal charges if we fail to follow these laws.

I authorize the following person/agency(s) to receive the specified information:

- Agency One
- Agency Two
- Agency Three
- Leave a few spaces blank.
- Leave a few spaces blank.

I authorize the following information to be disclosed:

- Histories and summaries
- Assessments or other evaluative information
- Treatment planning information
- Treatment attendance information
- Discharge information
- Leave a few spaces blank
- Leave a few spaces blank.

I authorize the released information to be used for the following reason(s):

- Care Coordination
- Care Transfer
- Family involvement in care
- Communications with criminal justice system.
- Leave a few blank
- Leave a few blanks.

I authorize the period of disclosure to extend until 30 days after treatment with Our Agency ends or the following date or event:

- This release of information expires on the following date: _____
- This release of information expires when the following event occurs:

I _____ have read and authorize the conditions of this release.
Please Print

Signature

Date

Template of a Qualified Service Organization Agreement²

Qualified Service Organization Agreement for *Services*.

[Specify services: i.e. mental health, emergency room treatment, insurance managed care, etc.]

The [place the non-substance abuse program here] and [place the substance abuse program here] hereby enter into a qualified services organization agreement, whereby the [the non-substance abuse program] agrees to provide the [substance abuse program] with the following services: [list all services that will be provided by the non-substance abuse program here]

Furthermore, the [non-substance abuse program]:

- (1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the [substance abuse program] about patients in the substance abuse program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and
- (2) Undertakes to resist judicial proceedings any effort to obtain access to information pertaining to patients otherwise expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2.

Executed this _____ day of _____, 2001.

[Signed non-substance abuse program official]

[Signed by substance abuse program official.]

² Adapted from LAC, 2000

References:

Legal Action Center. (2000). Confidentiality and communication: A guide to the Federal Drug and Alcohol Confidentiality Law (4th ed.). New York: Author.

McKinney's consolidated laws of New York (Book 34A: Mental hygiene law). (1996). St. Paul, MN: West Publishing.

Resources:

Legal Action Center of New York City, Inc.
153 Waverly Place
New York, NY 10014
(212) 243-1313 VOX
(212) 675-0286 FAX
Contact: Felix Lopez
Email: flopez@lac.org
Web site: <http://www.lac.org/>

American Psychological Association
Ethics Office
750 First Street N.E.
Washington, DC 20002-4242
(202) 336-5930 VOX
Contact: Stephe Brasfreud
Web site: www.apa.org

National Association of Social Workers
New York State Chapter
188 Washington Ave.
Albany, NY 12210
Phone: (518) 463-4741
Fax: (518) 463-6446
Contact: Barbara LaGrone, Ext. 10
Email: barbara_lagrone@naswnys.org
Web site: www.naswnys.org

NYS OASAS
Counsels Office
1450 Western Avenue
Albany, New York 12203-3526
518-485-2334 VOX
Contact: Rick Sudano, Chief Counsel
Web site: <http://www.oasas.state.ny.us/>

NYS OMH
Office of Counsel
John Tauriello, Deputy Commissioner and Counsel

Telephone: (518) 474-1331
FAX: (518) 473-7863
Web site: <http://www.omh.state.ny.us/>

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
Contact: Joe Fay
(301) 443-7017 VOX
Web site: <http://www.samhsa.gov/>