U.S. Department of Justice
Office of Justice Programs

Treatment Alternatives to Street Crime (TASC): Trainer's Manual

Bureau of Justice Assistance

TRAINING MANUAL

U.S. Department of Justice
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Treatment Alternatives to Street Crime (TASC): Participant's Manual

Training Manual

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September 1988

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Prepared under cooperative agreement number 86-SA-CX-K026
by the Florida Alcohol and Drug Abuse Association under
the direction of the National Association of State
Alcohol and Drug Abuse Directors

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The Assistant Attorney General, Office of Justice Programs, coordinates the activities of the following program Offices and Bureaus: National Institute of Justice, Bureau of Justice Statistics, Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, and Office for Victims of Crime.

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Assistance

Office of the Director

Washington, D.C. 20531

I am pleased to present this manual for instructing the case management model, Treatment Alternatives to Street Crime (TASC). The Bureau of Justice Assistance (BJA) has identified TASC as one of 11 "certified" programs eligible for block grant funding under the Justice Assistance Act of 1984 and the Anti-Drug Abuse Act of 1986. BJA's program brief for TASC identifies 10 program elements and performance standards as "critical" to the proper operation of a TASC program.

This manual is a guide for the trainer to instruct case management staff in the fundamentals of the TASC critical elements and how to effectively perform each. New staff will find the course an excellent orientation to the case management concept. Experienced staff will find the course a valuable review.

Sincerely,

Charles P. Smith
Director

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Treatment Alternatives to Street Crime

Critical Element Training

ACKNOWLEDGEMENTS

The contents of the TASC Critical Elements training course and manuals represent the joint effort of many contributors. Portions of the course were written by W. Chester Bell, Tom Turner, Foster Cook, Katie Nielsen-Nunez, Beth Weinman, Harvey Landress, Joe Infantino and myself. These individuals served as reviewers of various drafts and served as faculty for the field test of the course. The Bureau of Justice Assistance project officers, John Gregrich and Jody Forman, provided technical support and assistance in the development of these materials.

Thanks are also due to Carrie Gibson and Kari Bean who provided the secretarial support to make this project happen. Marion Ciaccio served as editor of the manuals and Majken Peterzen as graphic artist and designer.

All of the above contributed significantly in the development and production of this course. Their contributions are appreciated.

Mark P. Fontaine
Florida Alcohol and Drug
Abuse Association

INTRODUCTION

The Treatment Alternatives to Street Crime (TASC) Critical Elements training course has been developed for the National Association of State Alcohol and Drug Abuse Directors by the Florida Alcohol and Drug Abuse Association. The course was developed under a cooperative agreement with the Department of Justice, Bureau of Justice Assistance. Each of the contributors to the development of this training package has worked in TASC for a minimum of three years. The package has been written, revised, field tested and again revised in an effort to obtain a training design which covers all of TASC's conceptual bases in a stimulating format.

TASC is maturing as a field. This training package is designed to make TASC a permanent model for intervening with drug dependent offenders while fostering an orthodoxy among TASC sites which will serve to give all TASC projects a common language and philosophy. Finally, this training provides participants an opportunity to experience TASC as a generic model flexible enough to respond to the particular needs and demands of a local community.

This manual is designed to teach TASC staff the fundamentals of the TASC Critical Elements and how to effectively perform each of these. New staff would find the course an excellent orientation to the TASC concept and functions. While the manual is designed to cover the basics, more advanced or experienced TASC staff would find the course valuable as a review.

To effectively teach this course, the trainers must be experienced in TASC programming. The trainer manual lays out a clear picture of what material to cover during each module. However, if the trainers are not experienced in TASC programming they will have difficulty facilitating discussion and answering questions that relate directly to day-to-day experiences in a TASC program.

An important step in preparing to deliver the course is gathering local information from the states or localities of the trainees. In particular, the trainer wants to know:

- how the local criminal justice system is organized
- the anticipated TASC intervention points
- the availability of treatment
- whether minors may obtain treatment services without parental consent.

A thorough needs assessment and information gathering exercise by the trainers before they teach this course will help assure a smooth delivery and the necessary flexibility to make the course geographically specific.

Training Site Considerations

This course includes a variety of teaching methods and presentation styles to ensure that each learning objective is met. An assessment of the training site prior to delivery is necessary including review of classroom size, layout of the room, lighting and availability of audio visual equipment. When using an overhead projector, arrange the room to accommodate the visual in a forward projection. Avoid attempting to project around windows and exits. The second mode of delivery includes the use of flipcharts, especially during group exercises and feedback sessions. You must have an ample supply of durable tape and pins for placing flipchart sheets or poster boards on the walls. In those cases where the walls do not accommodate tape, (wallpaper, carpeting and acoustical materials), be prepared to use push pins or thumb tacks. In all cases, the training delivery should, to the extent possible, use the forward and side walls of the classroom. This should be the primary goal, but adjustments may be required, depending on the actual training site.

Course Format

Twelve (12) modules comprise the course. The trainer manual contains material on all twelve modules. The introduction to each module identifies the content to be taught, training materials needed, and the anticipated time required for delivery. The participant manual also contains twelve modules and corresponds with the trainer manual. Each module in the participant manual begins with a summary of the goals and objectives for that module followed by worksheets, factsheets, or articles relevant to content being delivered. The trainer(s) should familiarize themselves with the participant manual. The trainer manual refers to the participant manual throughout the course and the trainer should make the reference to the manual when appropriate.

The course is designed to be taught in twenty-three(23) contact hours. This breaks down to two (2) eight hour training days and one seven (7) hour day. Another option would be to teach the course over four days, allowing for travel time during the first morning and the final afternoon.

A proposed three-day training schedule breaks down as follows:

Day 1	Module	Time
8 hours	1-Introduction	1 hr., 25 min.
	2-Understanding TASC	1 hr., 35 min.
	3-TASC History/Elements	1 hr., 10 min.
	4-Establishing Support of Justice	2 hr., 45 min.
	5-Establishing Support of Treatment	1 hr.

Day 2

8 hours	5-Establishing Support of Treatment (cont'd)	1 hr., 15 min.
	6-Identification/Screening	2 hr., 20 min.
	7-Assessment/Referral	1 hr., 55 min.
	8-Case Management	2 hr., 30 min.

Day 3

7 hours	9-Urinalysis	1 hr., 5 min.
	10-Record Keeping	1 hr., 25 min.
	11-Confidentiality	3 hr.
	12-Special Populations	1 hr., 40 min.

The ideal approach is to teach the course beginning with Module 1 and ending with Module 12. This allows for maximum integration of the content and building from one module to the other. However each module is designed so that it could be taught in isolation. For some training events, all twelve modules might not be necessary due to the skills of the existing staff or specific program need. The trainer should feel free to restructure the design to meet the specific needs of the location where the training is to take place.

MODULE I: INTRODUCTION

TOTAL TIME: 1 hour 25 minutes

PURPOSE

This session is designed to familiarize the participants with each other and with the content of the course. Expectations for their involvement in the training will be presented along with the logistics of the training event.

OBJECTIVES

By the end of this session participants will be able to:

- List at least five topic areas that will be covered in the course.
- State at what time the training day is scheduled to begin and end.

MATERIALS/DOCUMENTS NEEDED

Participant Manuals
Overhead Projector
Overheads
Markers
Pretest
Name Tags
Flipchart Stand/Paper

MODULE I: INTRODUCTION

TIME/MEDIA & MATERIALS:	outline of training activities

15 minutes — **1. Pretest**

Pretest

As participants enter the training greet them and then ask them to fill out the pretest found on pages 3-4 of the participant manual. Encourage them to complete it to the best of their ability, emphasizing that the pre and post tests are mechanisms to evaluate the level of knowledge gained. Although the test itself will be anonymous, a code is needed to match the pre and post test. Suggest they use the first four numbers of their birth month and day (such as 1024 for October 24). If they choose, another code can be used. Stress the importance to use the same code on both the pre and post test. Allow approximately fifteen minutes for completion of the test. After collecting the completed pretest, proceed to the following activities.

5 Minutes — **2. Introduction to Training - Greeting**

You may want to have the local/state sponsoring agency introduce you to the participants. If no host is present, you should greet the participants and welcome them to the training.

20 Minutes — **3. Introduction of Trainers and Participants**

Very briefly sum up the purpose of the training - "We are here to teach the concept of TASC, the essential elements of TASC and practice skills in carrying out these elements". Let them know that next you will review the material covered over the next four days, but first you want to find out about the participants themselves.

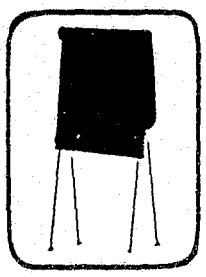
Introduce yourself and the other trainers. Each of the trainers should highlight their experience and training with TASC and the criminal justice and/or treatment system.

During this section you want the participants to become better acquainted with each other. The following exercise can be used but don't hesitate to substitute another exercise if desired.

Your should ask each participant to take one minute and answer the following questions:

- What is your job? How is it related to TASC?
- What is your experience with criminal justice and/or treatment?
- What is your experience with TASC?
- What do you do for fun?

20 Minutes **4. Needs Assessment**



FLIPCHART

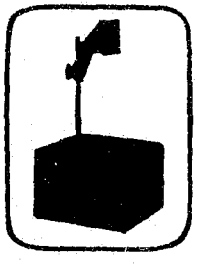
By now the trainees are more comfortable with the trainer and with each other. Ask each participant to take out a piece of paper and jot down at least two pieces of knowledge they hope to gain or two skills they hope to acquire during this workshop. Give them a few minutes to complete this task.

Ask the participants to get into groups of three. Then have them discuss their expectations for the course, reminding them to allow time for all members to express their expectations. Ask them to look for similar needs/wants. Allow approximately six minutes for this task.

Now you want to ask for feedback on needs and expectations. Solicit specific topics/issues that participants want to discuss during the training. As these issues are raised the trainer records them on a flipchart or overhead for all to see. Continue soliciting topics until everyone seems to have contributed.

15 Minutes **5. Course Overview**

Display Overhead 1. which reviews the course content (page 5 of the participant manual). If all topics on the overhead are not going to be covered, be sure to redesign it to reflect only those topics that will be covered in the course.



OVERHEAD
1

COURSE OVERVIEW

UNDERSTANDING TASC

TASC HISTORY AND ELEMENTS

CRIMINAL JUSTICE RELATIONSHIPS

TREATMENT RELATIONSHIPS

CLIENT IDENTIFICATION/SCREENING

ASSESSMENT/REFERRAL

MONITORING/CASE MANAGEMENT

URINALYSIS

RECORDKEEPING/DATA COLLECTION

CONFIDENTIALITY

SPECIAL POPULATIONS

Spend one minute on each topic to discuss what will be presented in that module. Be sure to cover the following:

- Understanding TASC - a presentation on what TASC is and how it fits as a bridge between the criminal justice and treatment systems.
- TASC History & Elements - history of TASC and what are the essential elements of a TASC project.
- Criminal Justice Relationships - how the criminal justice system works and where and how TASC links with this system.
- Treatment Relationships - what treatment is and how TASC works with the treatment system.
- Client Identification/Screening - the need for eligibility criteria, procedures and techniques for screening potentially eligible clients.
- Assessment/Referral - skills in conducting a TASC assessment and the essential ingredients for a referral.
- Case Management - skills in monitoring TASC clients and review of success/failure criteria.
- Urinalysis - the role of urinalysis in TASC, how it works, and how to maintain a chain of custody.
- Recordkeeping/Data Collection - the need for keeping good records and how these help manage TASC clients.
- Confidentiality - the alcohol and drug abuse confidentiality regulations and the restrictions they place on TASC work.
- Special Populations - special TASC considerations when working with adolescents, DUI cases, mental health clients and family violence offenders.

Once this discussion is completed, reflect on how the trainees' expressed needs will be covered in the proposed content. Be sure to indicate those issues that won't be covered in the session and suggest that you will meet with those people during breaks to offer suggestions on where to get the information and material they seek.

10 minutes **6. Logistics of the Training**

This is the time to discuss all of the logistical issues regarding the training. Any "house rules" should be presented at this time. If you are flexible on the training hours, smoking policy, etc., this is the time to discuss them. Work toward group consensus if there are any undecided issues. Be sure to cover at least the following items:

- number of days in training program
- starting and finishing time each day
- breaks: how often and how long
- lunch: how long and available facilities
- smoking policy
- rest rooms
- participant manuals
- continuing education credits (if applicable)
- other relevant issues

Ask participants if there are any questions or unresolved issues at this point. This is a good time for a break.

MODULE II: UNDERSTANDING TASC

TOTAL TIME: 1 hour 35 minutes

PURPOSE

This module is designed to provide participants with an understanding of the TASC concept and how the program acts as a bridge between the criminal justice and drug treatment systems.

OBJECTIVE

By the end of this session participants will be able to:

- Describe the TASC model through the use of a bridge analogy
- List the three primary client eligibility criteria necessary to receive TASC services.
- Define the four basic TASC services

MATERIALS/DOCUMENTS NEEDED

Participant Manuals
Overhead Projector
Overheads
Markers
Masking Tape
1/2" VCR & Monitor
Flipchart Stand/Paper

MODULE II: UNDERSTANDING TASC

TIME/MEDIA & MATERIALS:	outline of training activities

5 minutes **1. Introduction**

In this module, you will explain the TASC concept and its operation as a link between two very different systems. You will also be reviewing basic TASC services and discussing the TASC client.

Begin by giving the rationale for including a module on the TASC concept. Point out the importance of having a broad-based understanding of the concept and where it originated before learning how to perform the functions that the concept demands.

15 minutes **2. The TASC Client: Exercise**

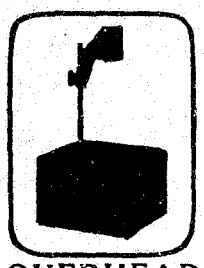
TASC programming was initially developed to identify the drug involved offender for the criminal justice system and to provide the appropriate case management services to that individual, or TASC client. The TASC client will now be discussed. Divide participants into groups of four. Provide each group with a piece of flipchart paper and ask the group to create a picture of the anticipated TASC client by visually rendering those features and behaviors of the typical client. Give them 10 minutes to develop their profile. Encourage the group to develop a consensus on the typical client.

Have each group pick a spokesperson to describe the TASC client profile. Do this quickly. The point of the exercise is to draw a conclusion that there <u>is</u> no typical client - TASC services a wide variety of individuals. The drawings should emphasize this point.

Trainer Note: Besides discussion regarding the TASC client, this exercise is designed to facilitate group bonding and cohesiveness.

10 minutes **3. The TASC Client: Lecture**

Take a few moments to summarize issues regarding the TASC client. The preceding exercise should have convinced the participants that there is no typical TASC client. He/she can be from any race, any level of involvement in the criminal justice system, charged with a variety of crimes, and have had varied experiences with treatment. The program's eligibility criteria (discussed in a later module) do in fact define who the TASC client is. There are, however, three criteria that all TASC clients will have in common. Display Overhead 2.



OVERHEAD 2

TASC ELIGIBILITY CRITERIA

1) JUSTICE SYSTEM INVOLVEMENT

2) SUBSTANCE ABUSE INVOLVEMENT

3) CLIENT PROVIDES INFORMED, VOLUNTARY CONSENT TO PARTICIPATE IN TASC

Discuss these three issues by highlighting the following points:

- justice system involvement as evidenced by formal charge, sentence, or diversion agreement;
- current or previous drug involvement as carefully defined and evidenced by client's own testimony, medical and/or social histories from other agencies, physical examination, urinalysis, and/or other laboratory tests;
- informed voluntary consent as evidenced by a signed agreement to participate in the TASC program and comply with the TASC, justice, and treatment requirements detailed in a written statement that is read to/by the offender before acceptance.

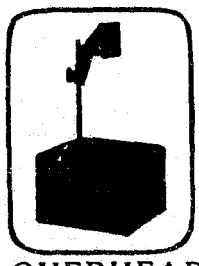
As you summarize these generic eligibility criteria, emphasize that they encompass each of the TASC system participants - the criminal justice and the treatment system both of which share the client.

20 minutes

4. The TASC Bridge: Lecture

Trainer Note: The overhead used in this section consists of two sections. Overhead 3A should be displayed first and discussed. Once completed, lay overhead 3B on top of 3A. This visual will then show how TASC is a bridge between the criminal justice and treatment systems.

The trainer should begin by discussing the goals of the criminal justice system vs. the goals of the treatment system as revealed in overhead 3A.

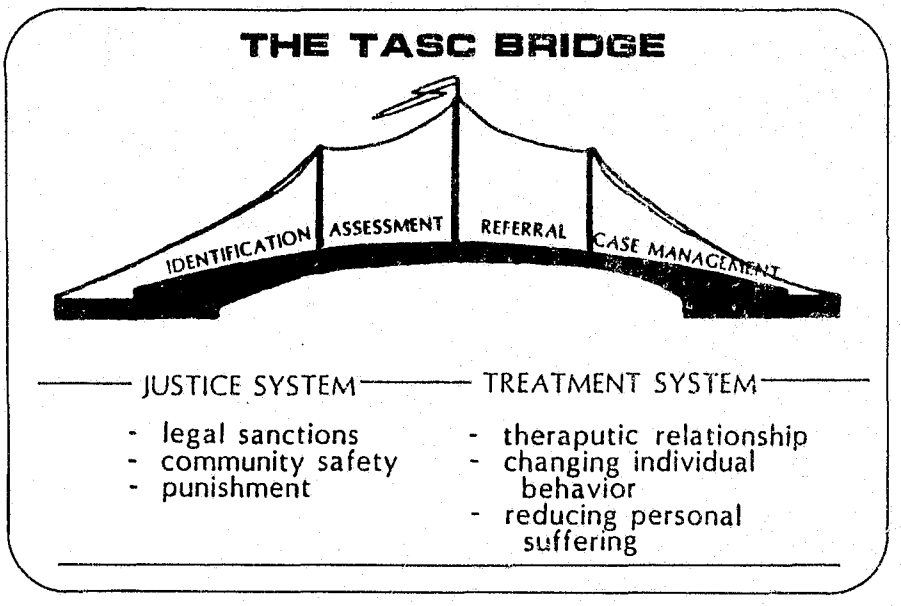


OVERHEAD 3A

JUSTICE SYSTEM	TREATMENT SYSTEM
- legal sanctions - community safety - punishment	- theraputic relationship - changing individual behavior - reducing personal suffering

Now you want to present an overview of the core TASC services. Highlight how each of these is a separate entity unto itself. When you combine these functions, the composite service is greater than the parts. The composite service is what bridges the gap between the criminal justice and treatment system because it identifies the drug involved individual and monitors him/her throughout treatment and justice involvement. Display overhead 3B.

OVERHEAD
3 B



Describe each of the TASC services highlighting the following:

Identification: the development of a specific methodology used to identify arrestees and offenders eligible for TASC services.

Assessment: the evaluation or appraisal of a TASC candidate's suitability for drug treatment and recommendation for a specific treatment modality/setting, giving full consideration to current and past use of drugs; justice system involvement; and medical, family, social, education, military, employment, and treatment histories.

Referral: the networking and communication with available treatment providers, which allows for an understanding of TASC°s assessment protocol and ensures acceptance of the TASC client into treatment upon TASC referral.

Case Management: providing an individualized scheme for securing, coordinating, and monitoring the appropriate treatment interventions and ancillary services for each TASC client's successful TASC, treatment, and justice system outcomes. Case management includes the application of TASC measures of client progress, success/failure criteria, full case documentation, treatment communication, and a regular reporting schedule to the criminal justice system.

Summarize by highlighting how the TASC concept is a link between the criminal justice and treatment system. Restate TASC's proven effectiveness as a means to link the individual efforts of the two systems in dealing successfully with the drug involved individual.

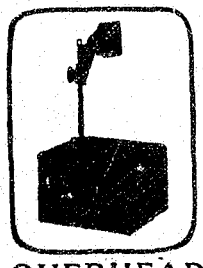
20 minutes

6. TASC Role

In performing these services, TASC staff work in both the criminal justice and treatment worlds, each different, but each affecting TASC programming. It is necessary for the TASC staff to recognize the differences in orientation and case flow in the two systems. TASC staff link the services of the treatment and criminal justice systems and help provide stronger communication and cooperation.

Exercise: Criminal Justice/Treatment Terms

Ask the participants to turn to page 10 in their participant manual. Give them four minutes to fill out the form. Ask them to indicate common words that are used by each system to describe the terms listed in the neutral column. Now display Overhead 4:



OVERHEAD 4

LANGUAGE DIFFERENCES

CRIMINAL JUSTICE AND TREATMENT

Criminal Justice System Terms	Neutral Terms	Drug Abuse Treatment System Terms
	Human Subject	
	Facility	
	Service	
	Period of Time	
	Presenting Problem	
	Accomplishment	
	Report	

Using the overhead, go down each column and ask the group for words that describe the neutral term. List the words on the overhead. Typical answers for each category appear below. Be sure the list generated includes these terms.

Criminal Justice System Terms	Neutral (abstract) Terms	Drug Abuse Treatment System Terms
Offender, Defendant	Human Subject	Client, Patient
Court, Jail	Facility	Treatment Program Therapeutic Community
Probation, Parole	Service	Counseling
Sentence	Period of Time	Treatment Phases
Arrest, Criminality	Presenting Problem	Addiction
Completion of Sentence	Accomplishment	Recovery, Abstinence
Pre-Sentence Investigation	Report	Treatment Notes

Discuss with the group how the language used by each system is distinct and unique to that system. Emphasize the point that very different languages are used by the treatment and criminal justice systems.

Point out the following:

- The two systems operate independently, although many individuals are involved in the justice system as a result of their need for treatment.
- TASC clients are moving through these two systems simultaneously, usually without any link between the two systems.

Summarize the section by pointing out that the criminal justice system and treatment system have different orientations, language, players, and mechanisms for dealing with clients/offenders. It is important to be familiar with these differences as one goes about trying to define the role and purpose of TASC and how TASC fits within these two systems

20 minutes

7. Summary: What is TASC

Nassau County Videotape

At this time you want to introduce the Nassau County videotape on TASC. This video tape was developed to provide information on TASC services.

Once the video has been shown, facilitate discussion regarding the participants' views of the video and the image presented. Several questions you may want to ask include:

- What essential concepts about TASC were presented?
- How did the presentation portray TASC as a service between the treatment and criminal justice system?
- Was TASC displayed in criminal justice or treatment language? (cite examples)

5 minutes

8. Conclusion

Summarize this module by using overhead 5, reviewing the following points (page 11 in the participant manual):

OVERHEAD 5

TASC Summary

> JUSTICE AND TREATMENT HAVE DIFFERENT ORIENTATIONS GOALS AND METHODS OF OPERATION

> TASC FACILITATES COMMUNICATION AND COORDINATION BETWEEN THE JUSTICE AND TREATMENT SYSTEMS.

> TASC CAN BE SEEN AS A BRIDGE THAT LINKS THESE SYSTEMS

> TASC SERVICES THAT LINK THESE SYSTEMS ARE IDENTIFICATION, ASSESSMENT, REFERRAL, AND CASE MANAGEMENT

> THERE'S NO TYPICAL CLIENT, BUT ALL CLIENTS SHOULD BE LEGALLY INVOLVED, A SUBSTANCE ABUSER, AND WILLING TO PARTICIPATE IN TASC VOLUNTARILY

Ask for any questions or unresolved issues. This is a good time for a break.

MODULE III:
TASC HISTORY & CRITICAL ELEMENTS

TOTAL TIME: 1 hour 10 minutes

PURPOSE

This module is designed to review for participants the history of the TASC concept and the critical program elements that make up TASC. It will provide a framework for understanding how TASC developed, why the concept has proven effective, and what essential elements are necessary for a program to be called TASC.

OBJECTIVE

By the end of this session participants will be able to:

- List four key steps in the development of the TASC concept
- List at least five TASC critical program elements
- Take three TASC critical program elements and list two performance standards used to measure compliance with the element.

MATERIALS/DOCUMENTS NEEDED

Participant Manuals
Overhead Projector
Overheads

MODULE III: TASC HISTORY & CRITICAL ELEMENTS

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes

1. Introduction – Why TASC?

This module will summarize the history of TASC, explain its evolution and tell why it is successful. The TASC critical elements will also be explained. A "critical element" is defined as those pieces any TASC program must have to succeed in its mission.

Researchers have documented the existence of a relationship between substance abuse and crime - a relationship that has long been evident to those working in the criminal justice system. A high percentage of all crimes are either directly or indirectly linked to drug or alcohol abuse. The following examples speak to the need for a program like TASC.

- the magnitude of the substance abuse problem;
- the high incidence of drug related crimes;
- the sheer volume of drug users being processed through the justice system; and
- the overcrowded conditions in most prisons and jails.

Ask the group for other examples that speak to the need for a program like TASC. Also solicit from their own jurisdiction(s) the following figures:

- percentage of arrests for specific drug charges
- percentage of drug related arrests
- percentage of prisoners in state correctional system admitting to substance abuse problems.

National statistics point out that 50-60% of crimes are drug related and at least 50% of prison inmates admit to serious drug or alcohol problems.

All of this makes clear the need for an alternative means for processing the drug abusing offender. TASC targets the person with a drug problem who often has a history of criminal activity and presents one of the highest risk categories in terms of successful rehabilitation.

30 minutes **2. History of the TASC Concept**

Trainer Note: Ask participants to turn to pages 13-14 of the participant manual and to make notes as you review the development of the TASC program.

Use the following chronology to discuss the evolution of TASC from a narrowly defined program model to the recognition of TASC as a concept that can be used in a variety of environments.

- 1962 - The 1962 Supreme Court decision, Robinson vs. California, defined chemical addiction as an illness rather than a crime. It held that the state could force an addict to submit to treatment and could impose criminal sanctions for failure to comply with the treatment program. At that time, alternatives to routine criminal justice system processing for drug dependent offenders seemed worthy of serious consideration.

- Early 1970s - A Special Presidential Commission on Drugs found that a small number of addicts were responsible for a large percentage of crimes.

- 1971 - The Special Action Office for Drug Abuse Prevention developed the initial TASC program model, which focused on linking criminal justice and treatment and interrupting the relationship between drugs and property crime.

- 1972 - The Law Enforcement Assistance Administration (LEAA) funded the first TASC program in Wilmington, Delaware. It provided pre-trial diversion for adult opiate addicts with non-violent criminal charges. Clients were identified in jail by urine tests and interviews. Successful completion usually resulted in dismissed charges, but few clients met these stringent eligibility criteria.

- 1973 - The National Institute of Drug Abuse (NIDA) funded eight TASC projects, and LEAA funded an additional five. LEAA program guidelines focused on pretrial diversion and sentencing alternatives. The program model was broadened to include polydrug abusers.

- 1974 - All TASC funding was consolidated under LEAA. The first evaluation study was completed by System Sciences. The study found:

  - TASC programs had a high proportion of repeat offenders with long histories of addiction
  - More than 55% of clients were receiving drug treatment for the first time
  - Criminal recidivism of TASC clients was lower than non-TASC clients

- 1975 - A total of 29 TASC sites were operational in 24 states.

- 1976 - Federal program guidelines were broadened to permit admission of clients whose sole drug of abuse was alcohol.

- 1978 - Phase II of the national evaluation was completed. This study found that:

  - TASC has support of both justice and treatment
  - TASC monitoring improved clients' treatment performance
  - TASC involvement seemed to reduce rearrest rates
  - TASC was a cost effective alternative
  - Staff quality was critical to a program's success.

- 1979 - LEAA provides additional TASC funding through the incentive program. This program:

  - Offered states grants to implement effective and proven criminal justice program. TASC was one of those programs.

  - Moved away from a pattern of direct federal funding to communities. Rather it gave the states management and control.

  - Emphasized statewide implementation.

  - Seven states developed networks of TASC programs: Arizona, Florida, Illinois, Michigan, New Jersey, Oklahoma, and Pennsylvania.

- 1980 - Congress abolished LEAA as an agency.

- 1980 through 1984 - Federal funding for new TASC starts ceased. State and local criminal justice and treatment agencies attempted to provide continuation funding for TASC.

- 1984 - Congress passed the Justice Assistance Act, which provided funding for programs to improve and expedite criminal justice processing. The legislation specified 18 funding purposes including "Purpose 8" programs, which "identify and meet the needs of drug-dependent offenders." TASC is one of only eleven models cited in the legislation as immediately eligible for funding, given its "proven" and successful track record.

- 1985 - Bureau of Justice Assistance begins making block grants to states and local governments to begin new TASC programs or enhance existing ones.

- 1986 - Congress passed the 1986 Drug Enforcement, Education and Control Act, which provides block grants to states to improve state and local drug abuse control efforts. TASC is a program model that meets three of the seven approved purposes for use of these funds.

- 1986 - The TASC critical elements and performance standards are developed.

- 1986 through 1989 - The Bureau of Justice Assistance makes funds available for training and technical assistance services to TASC and other case management programs.

Summarize this section on the history of TASC by pointing out:

- TASC programs have been established and organized in a wide variety of jurisdictions and geographic areas: rural and urban areas, regional conglomerations, and statewide networks.

- Original narrow eligibility criteria have been expanded to include polydrug and alcohol abusers, juveniles, and in some areas, mentally ill and domestic violence offenders.

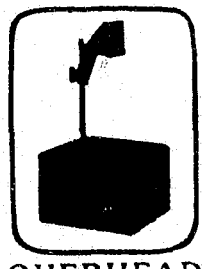
- The Federal support and funding has been inconsistent over the last 15 years. The latest funding hiatus damaged field communication, making it clear that a training and technical assistance effort was needed to foster communication and ensure continuity among TASC and TASC like programs.

30 minutes

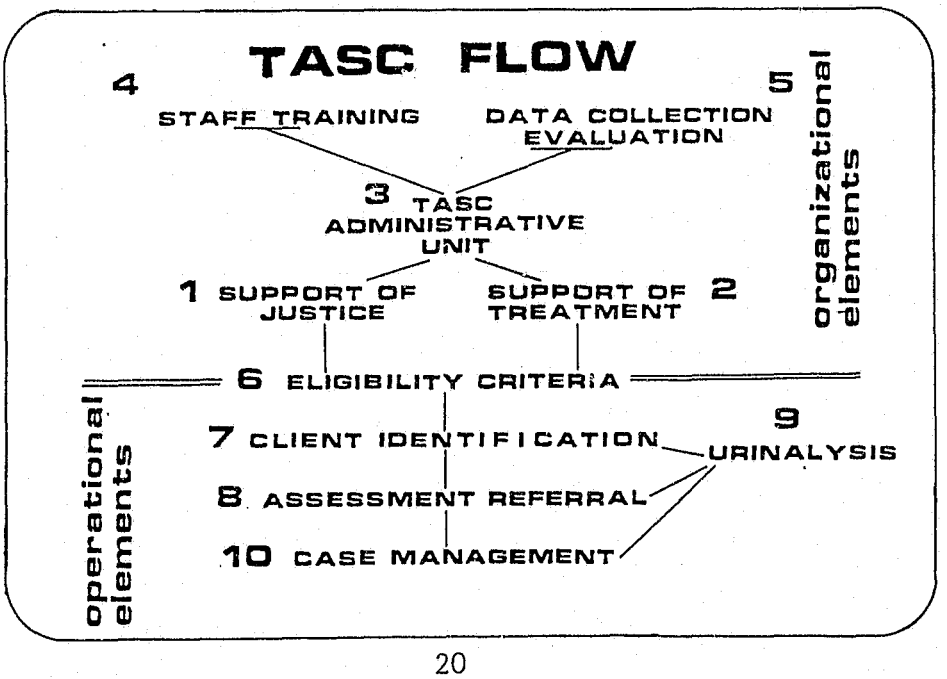
3. Critical Elements of TASC

Certain critical elements have proven to be critical to the success of a TASC program. Cases where TASC has failed can usually be traced to neglect of a certain key step. Experience has shown the TASC model is highly transferable if the following elements are incorporated.

Trainer Note: Make yourself familiar with all critical elements and performance standards. Use prepared overheads to guide this session. Start by displaying Overhead 6, the flowchart diagram of the critical elements. Refer trainees to the participant manual (page 15) for a copy of TASC flow overhead.



OVERHEAD 6



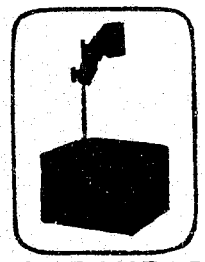
Emphasize that the elements can conceptually be broken into organizational and operational elements. The first five are organizational elements: those administrative systems and services that must be in place for the client services to work. The operational elements are the actual services to the TASC client and thus the treatment and criminal justice system.

After reviewing the 10 Elements go back and discuss each one separately with emphasis on the performance standards. These standards were set up to guide implementation and provide a means to completion of the element. Overheads 7 - 16 summarize the elements. Refer participants to pages 16 - 17 in the participant manual.

OVERHEAD 7

element 1 BROAD-BASED SUPPORT BY THE JUSTICE SYSTEM

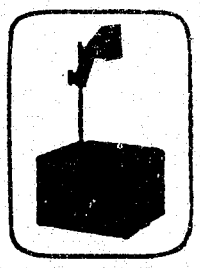
- Formal agreements outlining responsibilities and expectations for TASC and criminal justice agencies
- Clear procedures for communication - reports, schedules, etc.



OVERHEAD 8

element 2 BROAD-BASED SUPPORT BY THE TREATMENT COMMUNITY

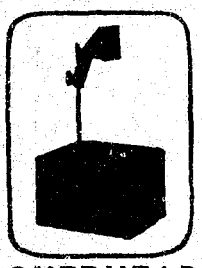
- Formal agreements outlining responsibilities and expectations for TASC and treatment agencies
- Satisfaction of state licensing requirements (if appropriate)
- Clear procedures for communication - reports, schedules, etc.



OVERHEAD 9

element 3 AN INDEPENDENT TASC UNIT WITH A DESIGNATED ADMINISTRATOR

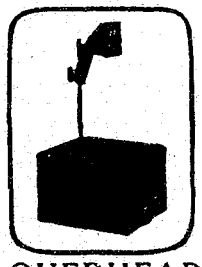
- TASC an independent agency or a separate unit of the host agency
- A full-time qualified administrator



OVERHEAD 10

element 4 POLICIES AND PROCEDURES FOR REGULAR STAFF TRAINING

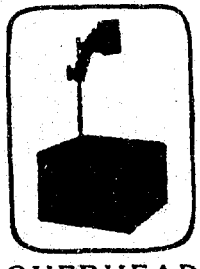
- A plan that assures 32 hours yearly of relevant training for all TASC staff
- Agency policies and procedures made available to all staff



OVERHEAD 11

element 5 A MANAGEMENT INFORMATION - PROGRAM EVALUATION SYSTEM

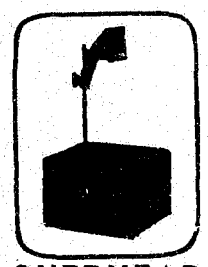
- Define standardized reports for data collection
- Collection of data on:
  - number of clients identified/referred/accepted from different justice agencies
  - client profile information
  - amount/type of client termination outcomes
  - services provided by TASC staff
- Analysis of data, use in evaluation and reporting to administration and staff
- Reporting of data to appropriate personnel for program evaluation and management



OVERHEAD 12

element 6 CLEARLY DEFINED CLIENT ELIGIBILITY CRITERIA

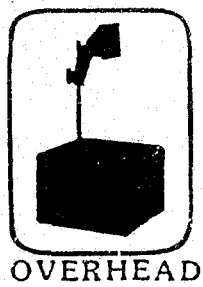
- Client eligibility criteria that must include at minimum
  - justice involvement
  - current and/or previous drug dependence
  - voluntary informed consent
  - clarification of criteria with justice and treatment personnel
- Regular review of program compliance to the criteria.



OVERHEAD 13

element 7 SCREENING PROCEDURES FOR EARLY IDENTIFICATION OF TASC CANDIDATES WITHIN THE JUSTICE SYSTEM

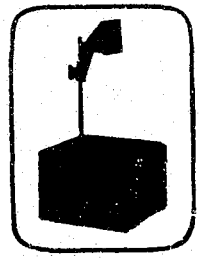
- o Methodology for client identification
- o Screening procedures that emphasize:
  - early intervention
  - early release into treatment



OVERHEAD 14

element 8 DOCUMENTED PROCEDURES FOR ASSESSMENT AND REFERRAL

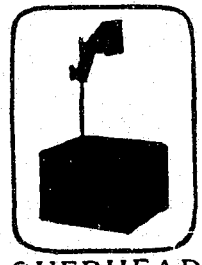
- o Documented face-to-face interview
- o Adherence to eligibility criteria
- o Referral to and acceptance by treatment within 48 hours of TASC assessment
- o Development of contingency procedures for monitoring clients if treatment not immediately available (office monitoring, jail groups, etc.)



OVERHEAD 15

element 9 POLICIES, PROCEDURES, AND TECHNOLOGY FOR MONITORING TASC CLIENTS' DRUG USE/ABUSE STATUS THROUGH URINALYSIS OR OTHER PHYSICAL EVIDENCE

- o Urinalysis procedures that maintain chain of custody
- o Specified testing frequency for each level of participation.
- o Formal contracts with certified or licensed laboratories.



OVERHEAD 16

element 10 MONITORING PROCEDURES FOR ASCERTAINING CLIENT'S COMPLIANCE WITH ESTABLISHED TASC AND TREATMENT CRITERIA AND REGULAR PROGRESS REPORTING TO REFERRING JUSTICE SYSTEM COMPONENT

- o Clear success/failure criteria
- o Individual client treatment and TASC case management plans
- o Reporting procedures
- o Freestanding TASC client files that document progress in the program.

5 minutes

4. Summary

Trainer should close this session by reflecting on the commonality of the critical elements to all TASC programs and mention that the rest of the training is based on these elements. You should also talk briefly about the rationale for basing the national training and technical assistance program on these elements. Point out that use of a common frame of reference enhances communication and understanding among program staff (orthodoxy), makes it easier to replicate the program model (transferability), and contributes to long term stability (permanency) of the TASC concept.

MODULE IV:

ESTABLISHING BROAD BASED SUPPORT OF THE JUSTICE SYSTEM

TOTAL TIME: 2 hours 45 minutes

PURPOSE

This module is designed to provide participants with an overview of the criminal justice system, how TASC can effectively integrate with that system, and how to establish and maintain necessary communications and firm linkages between the two systems.

OBJECTIVES

By the end of this session participants will be able to:

- List eight stages of criminal justice processing
- Describe the process by which TASC can intervene in at least three of those stages
- Identify four TASC benefits to the criminal justice system
- List five techniques for effective jail work
- List five strategies for complying with court protocol

MATERIALS/DOCUMENTS NEEDED

Participant Manual
Overhead Projector
Overheads
Markers
Handouts
15 2' x 3' Poster Boards
15 5" Cardboard Stars
Masking Tape
Flipchart Stand/Paper

Copies for role play scripts for activity 11

Information on steps in justice system processing
in the area where training is being conducted

MODULE IV: ESTABLISHING BROAD BASED SUPPORT OF THE JUSTICE SYSTEM

TIME/MEDIA & MATERIALS:	outline of training activities

Trainer Note: Before presenting this module you should obtain an outline of the common steps in criminal justice processing in the area (state) where training is to be presented. This background is essential to accurately present the materials in sections 2, 3, and 4 of this module. In addition, you will likely find that several trainees are knowledgeable about the justice process in their area. Use this knowledge to clarify questions that may be beyond your own knowledge.

5 Minutes

1. Module Overview

Give the rationale for including a module on the criminal justice system. Emphasize that TASC is a bridge between the criminal justice and treatment systems. To clearly understand the role of TASC in this process it is important to understand the criminal justice system - how it works and how TASC interacts with it.

10 Minutes

2. The Criminal Justice System: Exercise

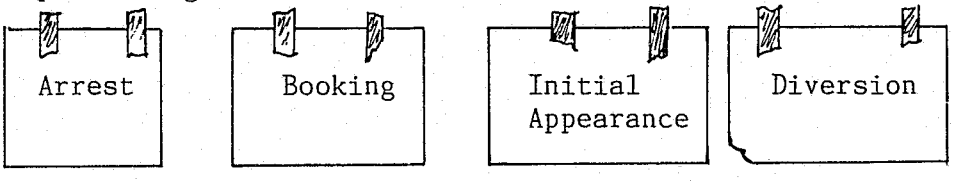
Facilitate an exercise on the criminal justice system. Before the session begins, write the following stages of the criminal justice system - each stage on separate sheets of 2' x 3' poster board.

As noted above, be sure to obtain an accurate list of stages in the local criminal justice system. Generally, the progression will follow in the following order:

1. Arrest
2. Booking
3. Initial Appearance
4. Diversion
5. Arraignment
6. Pretrial Conference
7. Trial
8. Pre Sentence
9. Sentencing
10. Probation
11. Incarceration
12. Parole

Ask for a group of volunteers equal to the number of steps that you have developed.

Have each volunteer take a piece of the poster board and some tape for hanging the poster board. Ask each one to hang the pieces in the order of logical flow (arrest through parole) used by the criminal justice system. Thank the volunteers and invite them to sit down. The charts should be displayed in sequence of processing as demonstrated below:



15 Minutes

3. The Criminal Justice System: Discussed

During this time you want to go through each component of the criminal justice system. Describe what happens at this point and how it happens. Because you want to know what the trainees have experienced in their own cities and towns, be sure to seek their comments to assure that those comments reflect the process of their local systems. Also reflect on any discussion or indecision group members had while trying to get their systems in order. Mention that this whole discussion will focus on a felony processing model: misdemeanor and juvenile systems are different.

Now you as the trainer want to overview what happens in each of these stages. Using the following order and points, go to each poster board and explain the essential components of that stage of justice processing.

- Arrest - the holding in legal custody either made at scene of crime or as a result of investigations. Could also be result of complaint filed by a third party, outstanding warrant, or revocation of probation or parole.

- Booking - the process of being admitted into detention.

- Initial Appearance - appearance in court before a magistrate where bond is set or determination is made to retain in jail or release.

- Arraignment - appearance in court when the accused is formally charged with a crime.

- Pretrial Conference - The prosecutor, defense attorney and judge meet prior to trial to establish parameters for the trial. Often a plea is negotiated at this point.

- Trial - court hearing where prosecutor presents case against the defendant to show he/she is guilty of the accused crime. Judge or jury decides verdict.

- Pre-Sentence Investigation - if the client has been found guilty, a comprehensive report including social, criminal and other histories. The report will usually include a recommendation for sentencing.

- Sentencing - disposition of a case, where penalties are imposed.

- Probation - sentence of community-based supervision. Includes stipulations and prohibitions of certain activities, often includes fines.

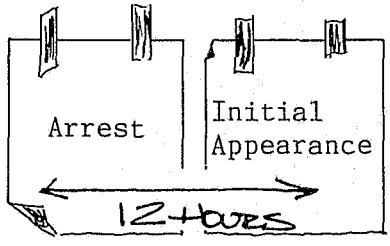
- Incarceration - sentence of imprisonment, either in state prison or local jail.

- Parole - process of being released from prison before maximum completion of sentence. Parole involves stipulations and prohibitions on certain activities.

5 Minutes

4. Criminal Justice System Timeframes

During this period you want to discuss the time it takes to move through the criminal justice system. Go to the poster boards and ask for group feedback on how long it takes to move from arrest to initial appearance. Look for group clarification. This process will enable all participants to think in the same timeframes. Indicate with different colored lines on the poster board the time between components. For example, the participants state that within 12 hours of arrest an initial appearance is made. Show the process on the poster board as follows:



20 Minutes

5. Criminal Justice System: Terminology

This section discusses terminology to make the participants aware of the definitions of terms commonly used by the criminal justice system. Have them turn to page 20 in the participant manual and write a brief definition of the terms listed. Give them 10 minutes to complete the list.

Once they have completed the assignment go through each term and ask one participant for a definition. Then if anyone else has another definition, work to create a consensus. Record the definition on an overhead or flipchart. The following definitions will help you in this process:

- Rap Sheet - record that contains all arrests on offender
- Docket - order of cases to come before the judge
- Felony - major criminal offense
- Misdemeanor - minor criminal offense
- Speedy Trial - right to trial within 180 days
- Court Order - decision of the court, often mandating certain behaviors
- Diversion - a process whereby a defendant is not adjudicated if certain conditions are met.

- ROR - release on own recognizance
- Bail - an amount of money set by judge to assure an appearance at court
- Bond - percent of bail actually paid
- Plea Bargain - a negotiated deal on penalty for alleged crimes
- Capias/Warrant - judge's order to rearrest individual
- Nolo Contendere - plea, neither admitting or denying guilt

20 Minutes

6. Exercise: The Criminal Justice System Players

Now it is time to look at the players in the justice system. Assign the following titles to volunteers:

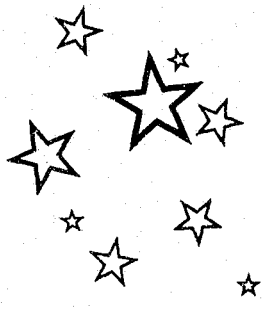
- police officer/sheriff
- judge
- probation officer
- parole officer
- bail bondsperson (if applicable)
- arrestee
- court clerk
- prosecuting and defense attorney

After assigning roles, have the volunteers go to the poster board one at a time and print the name of his or her player below each of the points on the criminal justice system where that player is involved.

After the volunteers have completed their work ask the trainees if they have any questions or concerns regarding the actors listed at each stage of processing. Make adjustments as necessary to achieve accuracy and consensus. Be sure to discuss each of the players and their role in criminal justice processing.

20 Minutes

7. Criminal Justice System - TASC Intervention Points



Trainer Note: Before beginning this section, prepare 15 red cardboard stars.

TASC programming can be implemented at a series of locations in the criminal justice system. Place a red star on each component of the criminal justice system where TASC can be implemented.

Facilitate a group discussion on how TASC can be involved at each location that has been starred. Be sure the discussion includes:

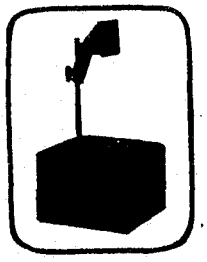
- how TASC works at this point

- some of the issues to be considered regarding TASC involvement at this point

The following points are examples:

- Booking: Can identify potential clients, assist in obtaining early release
- Initial Appearance: Can identify potential clients, facilitate release
- Arraignment: Can identify potential clients, facilitate release
- Pretrial Conference: Can provide an alternative to further criminal justice processing, make recommendations.
- Presentence Investigation: Can make recommendation for appropriate case disposition. Provide data on evaluation or client's participation in program up to that point.
- Sentencing: Can make recommendation for appropriate case disposition. Provide evaluation data or information on client's participation in program.
- Parole/Probation: Can provide monitoring of client progress in treatment and feedback to supervising agency.

Finish the discussion with an emphasis on the TASC program intervening in the criminal justice system as early as possible. Take two additional stars and place them at the booking stage. Be sure to point out that TASC should be considered as early as possible for the following reasons (refer participants to page 21 in their manuals):



OVERHEAD 17

RATIONALE FOR EARLY TASC INTERVENTION

Reaches client at point of greatest need/motivational level

Provides maximum information to court before disposition

Saves money, time, and resources for both corrections and court system

Increases likelihood of successful TASC and treatment participation

Strengthens client motivation for treatment

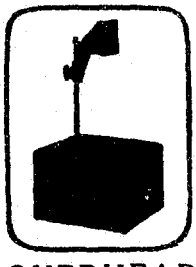
Provides data to court at time of sentencing

10 Minutes

8. Criminal Justice System - TASC Benefits Presentation

TASC provides an objective and effective bridge between two separate and sometimes opposing institutions: (1) the justice system, whose legal sanctions reflect community concerns for public safety and punishment and (2) the treatment community, whose emphasis is on creating therapeutic relationships as a means for changing individual behavior and reducing the personal suffering associated with substance abuse. Under TASC auspices, community-based treatment is made available to drug dependent individuals who would otherwise burden the justice system with their persistent criminality. TASC offers specific benefits to the criminal justice system.

Display Overhead 18 and explain the benefits of TASC to the criminal justice system, including specifics on why these are beneficial. Refer participants to page 22 in their manuals.



OVERHEAD 18

TASC ***BENEFITS TO CRIMINAL JUSTICE SYSTEM***

JAIL - reduces tension,
discipline problems,
overcrowding

COURT - additional information,
focus resources

PROBATION - additional supervision

PAROLE - continuity of care

COMMUNITY - reduced cost,
increased public safety,
reduced criminal activity,
reduced drug use

Cover the following points and then ask the group for their comments or additional issues that ought to be discussed:

- TASC benefits the jail by relieving jail tensions, discipline problems, the associated drain on custodial resources, and general overcrowding
- TASC benefits the court by providing the court with additional dispositional alternatives for dealing with drug abusing offenders;

- TASC allows the court to focus its resources on those types of cases where deterrence oriented criminal prosecution can better achieve results

- TASC reduces the costs incurred by the system in full criminal processing

- TASC provides probation with additional supportive services needed for effective supervision of its caseload and links the TASC client to relevant treatment services.

- TASC provides parole agencies with treatment options which ensure continuity of care as the inmate returns to the community.

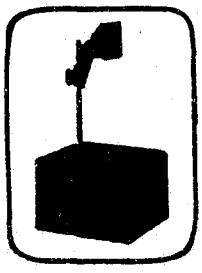
- TASC benefits the community by increasing public safety through the provision of structured, supervised release of substance abusing offenders, reducing the criminal activity related directly or indirectly to drug abuse, and providing community based treatment on a selective basis in lieu of incarceration

10 Minutes

10. Formal Agreement/Protocols

The success of TASC is rooted in establishing clear communication between criminal justice and treatment so that both systems work in partnership to best meet the needs of the individual client. Relationships between TASC and the various criminal justice agencies (state attorney's office, public defender's office, probation, parole, the jail, etc.) should be negotiated and summarized in written letters of agreement. The process of developing these agreements helps define and clarify roles and expectations.

Examples of what formal agreements between TASC and justice should include are summarized in overhead 19. Advise participants that these examples are included in their participant manuals on page 23. After reviewing the examples solicit additional ideas from the group regarding other conditions that could be required of TASC or criminal justice.



OVERHEAD 19

AGREEMENTS WITH CRIMINAL JUSTICE SYSTEM

TASC AGREES TO PROVIDE:

- specific points of intervention
- time frames for action on referrals
- frequent client contact
- frequent client progress reports containing objective information
- time frames for notification of client termination, client disappearance, etc.
- criteria for termination from TASC

overhead 19

continued on next page

overhead 19 continued

CRIMINAL JUSTICE AGENCY AGREES TO PROVIDE:

- booking log, interview access
- interview space
- access to jail
- access to inmates
- arrest reports
- appropriate response to notification of client success and/or failure in treatment
- agreement to refer consistently eligible clients to TASC
- personnel to support TASC in an advisory role

35 Minutes

11. Formal Agreements Exercise

Trainees should be divided into groups of three. Assign each trainee in each group a role as TASC Director, Corrections Administrator or Chief Judge. Provide each with a copy of the following role instructions: TASC Director, Chief Judge, Correction Administrator.

Trainer Note: The three scripts are printed on the last page of this module. Use this master to photocopy the required number of scripts for the group you are training.

Advise each of them not to divulge their information to the other two members in the group.

Inform each of the groups that today the TASC Director, the Corrections Administrator and the Chief Judge are meeting to reach an agreement on services TASC will provide to the local criminal justice system. They are to determine:

- client eligibility criteria
- protocols for TASC screening in the jail
- progress reporting procedures
- treatment referral procedures

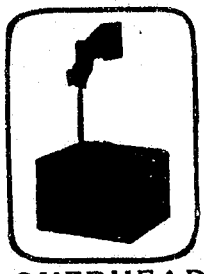
Allow 20 minutes for discussion and work towards an agreement on the four issues to be discussed. Have each group report what it agreed to using the elements of cooperative agreements found on page 23 in the participant manual. Once the exercise is completed, process it by asking the following questions:

- Who were the winners and losers in your negotiations?
- Were there any insurmountable issues?
- Are there any lessons to be learned or conclusions reached about developing letters of agreement as a result of doing this exercise?

5 minutes

12. Formal Communication Mechanisms

The existence of an agreement does not constitute communication, it is only the foundation of communication. Once agreements have been developed, formal and informal communication mechanisms can be used to meet the objectives. Formal communication mechanisms can include:



OVERHEAD 20

Formal Communication

PROGRESS REPORTS

WARNING LETTERS

TERMINATION LETTERS

COURT TESTIMONY

Inform participants that this material is highlighted on page 24 in their manual. Explain the information on the overhead by covering the following points:

- Progress Reports - an accounting of client progress on specific objective criteria. Progress reports are submitted on a regular basis - weekly, monthly, or other agreed upon time.

- Warning Letters - notification to court and client that client's TASC status is in jeopardy. Should include citing of objective data that verifies the problem.

- Termination Letter - timely notification to court and client that client has been successful/failed to meet outlined criteria. Objective data to back up termination and date of termination should be available.

- Court Report/Testimony - provision of oral or written information on client's progress

As with all systems, the criminal justice system relies heavily on informal information exchange. It is important for TASC staff to become a participant in this informal network, but at the same time, client confidentiality must be respected. By understanding and using the informal communication channels, TASC staff can enhance their credibility with the criminal just system and better serve the client.

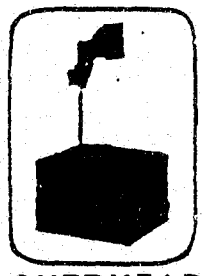
5 Minutes

13. Jail and Courtroom Do's and Don'ts

TASC staff working in the jail should be aware of their surroundings and the effect they have both on offenders and correctional staff. Physical conditions, jail rules and procedures, and staff attitudes will all have an effect on TASC operations.

TASC staff often have their first contact with an arrestee soon after booking. This can be one of the most stressful points for the offender as he/she adjusts to unfamiliar surroundings, rules, and other prisoners. Trying to conduct an interview under these circumstances can be difficult.

In general, TASC staff should bear in mind the following. Refer participants to page 25 in their manuals.



OVERHEAD 21

Jail and Court -- Do's / Don'ts

DO'S

Do learn and respect jail and court policies, procedures, and schedules.

Do maintain a professional demeanor with both clients and staff (correctional officers, judges, attorneys) at all times.

Do dress appropriately at all times - especially in court.

Do use stipulations and draft orders to obtain court action.

Do tell the bailiff the nature of your business when you enter the court room.

DON'TS

Don't be drawn into discussions with clients about complaints of unfair treatment or give advice about problems outside those that are directly TASC related.

Don't joke about drugs or crime with prisoners, or make comments about criminal justice staff or other inmates (whether good or bad).

Don't violate confidentiality of clients

Don't speak in court unless requested to do so by judge.

5 minutes

14. Module Summary

Summarize the module with the following information.

To be effective with criminal justice TASC must:

- Be knowledgeable about the criminal justice process.
- Develop formal agreements with justice that legitimatize TASC's role in the system.
- Maintain formal communication links with the criminal justice system.
- Act professionally at all times when interacting with criminal justice.

Ask for any unresolved questions or issues at this point. A break is in order.

TASC DIRECTOR: Wants to obtain agreement that will:

1. Allow TASC screeners to travel freely throughout the jail.

2. Authorize TASC as sole agency to conduct drug abuse assessments as a part of pre-sentencing investigation

3. Obtain order that all arrestees will be screened for drug use via urinalysis with those who test positive referred to TASC for screening.

   - You are willing to negotiate issues 2 to 3, but are very firm about issue 1

CHIEF JUDGE: Wants to obtain agreement that will:

1. Allow misdemeanor court judges to refer defendants to TASC for probation supervision.

2. Require immediate notification to judge, prosecutor, and/or probation officer of any positive urinalysis.

3. Allow the court to refer defendants to specific treatment programs, then require TASC to monitor progress in treatment and conduct urinalysis.

   - You are willing to negotiate on issues 2 and 3, but are very firm about issue 1

CORRECTIONS ADMINISTRATOR: Wants to obtain agreement that will:

1. Limit TASC staff working hours in jail to the hours of 4:00 p.m. and 10:00 p.m.

2. Require TASC staff to be accompanied by corrections officers whenever they are in the jail, with contraband searches conducted upon entering.

3. Require TASC to file copies of all screening and assessment work with the jail's case management supervisor.

   - You are willing to negotiate on issues 2 and 3, but are very firm about issue 1

MODULE V:

BUILDING BROAD BASED SUPPORT OF THE TREATMENT SYSTEM

TOTAL TIME: 2 hours 15 minutes

PURPOSE

This session is designed to provide trainees with an overview of substance abuse treatment. The purpose is to explore and identify those means by which TASC can work effectively with the treatment system.

OBJECTIVES

Upon completion of this module, participants will be able to:

- Provide a definition of substance abuse treatment and list at least four substance abuse treatment modalities.
- Describe three strategies that TASC can use to develop and maintain good relationships and communication with treatment.
- Identify three potential barriers to good relationships and communication between TASC and treatment providers.
- List five issues that must be clarified in letters of agreement between TASC and treatment providers.

MATERIALS/DOCUMENTS NEEDED

Overhead Projector
Overheads
Markers
Film: The Intervention
1/2" VCR and Monitor
Flipchart Stand/Paper

MODULE V: BUILDING BROAD BASED SUPPORT OF THE TREATMENT SYSTEM

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes

1. Introduction

Explain the purpose of the module highlighting the three goals:

- To become knowledgeable about treatment including modalities of substance abuse treatment, availability of these modalities in the local community, and identification of which treatment modalities are most effective in treating different degrees of abuse/addiction.

- To identify the means by which TASC and treatment can work effectively to serve mutual clients including establishing policies and procedures that assure good communication between TASC and treatment, while limiting the opportunity for clients to play one system against the other.

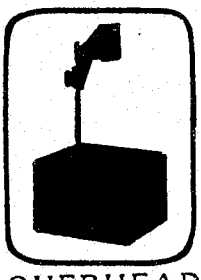
- To identify the treatment modalities that must exist in the community to assure the viability of the TASC model. For instance, a community with a significant population of opiate addicts must have detoxification facilities, methadone and residential programs in order to adequately address the needs of this addict population.

Trainer Note: You should presume that some participants may have worked in the treatment system. Therefore, you should draw upon and make use of their knowledge as you present this module.

25 Minutes

2. Definition of Treatment and Description of Substance Abuse Treatment Modalities

Begin by defining treatment as reflected on Overhead 22.



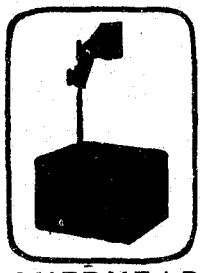
OVERHEAD 22

TREATMENT

ANY INTERVENING FACTOR HAVING THE POTENTIAL EFFECT OF CHANGING BEHAVIOR THAT HAS BEEN PREVIOUSLY JUDGED AS NEEDING TO BE CHANGED.

More specifically, treatment for substance abuse involves planned, therapeutic intervention with discontinuing the substance use or abuse as the ultimate goal. While traditional counseling and psychotherapy interventions are most commonly the core of treatment, it may also consist of various auxiliary services that will assist in the client's rehabilitation.

Substance abuse treatment generally consists of specific modalities that are designed to meet a particular client's needs for degree of structure.

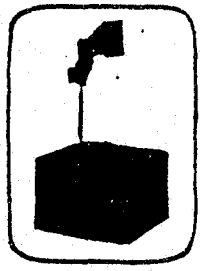


OVERHEAD 23

TREATMENT MODALITIES

SPECIFIC MODALITIES OF SUBSTANCE ABUSE TREATMENT DESIGNED TO MEET A CLIENT'S NEED FOR STRUCTURE, RANGING FROM VERY RESTRICTIVE (HOSPITALIZATION, INPATIENT) TO NON-RESTRICTIVE (SELF-HELP GROUPS, DROP-IN COUNSELING CENTERS)

Individual circumstances will dictate the placement of a client into a program or modality that can be viewed on a continuum from a less restricted environment to one of highest restriction. The most common modalities for substance abuse treatment are:



OVERHEAD 24

MODALITIES OF TREATMENT

DETOXIFICATION
METHADONE TREATMENT
LONG TERM RESIDENTIAL
SHORT TERM RESIDENTIAL
HALFWAY HOUSE
DAY TREATMENT
DRUG FREE OUTPATIENT
SUPPORT GROUPS
EDUCATION GROUPS
FAMILY EDUCATION GROUPS
AUXILIARY SERVICES

Define each modality on the treatment continuum. Solicit input from the participants as you expand or clarify the definitions. Utilize the experience of the participants regarding the treatment modalities in their community.

Explain each modality being sure to highlight at least the following points (page 27 in the participant manual):

- Detoxification - structured medical or social mileau in which the individual is monitored while undergoing withdrawal from the acute physical and psychological effects of addiction.

- Methadone Treatment - An outpatient mode of treatment for opiate dependent persons. Involves counseling, urinalysis, and the supervised dispensing of daily oral doses of methadone. Methadone is a long-acting narcotic. Methadone maintenance involves dispensing to a client a stable dose of methadone but not enough to make the client "high." Methadone detoxification is the process of reducing the dose of methadone over a given time to "wean" the client from opiates. Benefits include the termination of IV drug use and its physical complications; no "highs" and "sickness"; no need to steal to support an expensive habit.

- Long Term Residential - inpatient, usually six to twenty-four months in duration with gradually increasing levels of responsibility and privilege. Often in three major phases: inpatient, live-in/work-out, after care. Also known as Therapeutic Community, which is run on a family principle. Each client is a member of the family.

- Short Term Residential - 28-day inpatient (may be as long as 90 days) and may include detoxification as the first stage.

- Halfway House - transitional facility where client is involved in school, work, training, etc. Lives on site while either stabilizing or reentering society drugfree. Usually involved in some individual counseling as well as group, family, or marital therapy.

- Day Treatment - client resides at home while attending counseling/treatment 4-8 hours per day, 5-6 days per week.

- Drug Free Outpatient - client lives away from treatment center. May be working or in school, sees therapist one to five times weekly for counseling which may include individual, group, or family therapy. Can be the primary modality of choice or may be part of the transition process from more restrictive to less restrictive therapeutic environment.

- Support Groups - self-help peer groups for mutual support such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Adult Children of Alcoholics (ACOA) groups. Meetings are either open or closed and occur at various times daily or weekly.

- Education Groups - seminars, workshops, specific interest meetings designed for increased awareness around a particular topic.

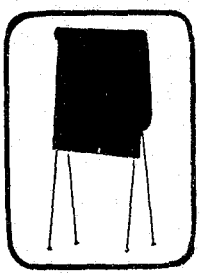
- Family Education Groups - structured education sessions to inform family members of issues with chemical dependency.

- Auxiliary Services - supplemental services provided outside the treatment facility such as job placement, training, food stamps, vocational rehabilitation.

Regardless of the modality where the client begins treatment, it is important to maintain a continuum of care throughout the treatment process to ensure the best services possible.

20 Minutes

3. Treatment Availability and Strengths



FLIPCHART

Using a flipchart, have the participants identify the various treatment modalities in their community by name and type. List each on the flip chart in order of most restrictive to least restrictive. Ask the group to identify gaps in the service delivery continuum.

Trainer Note: If working with several TASC sites be sure to break the participants into small groups, with those from the same community/agency being in the same group. Have a participant in each group do the listing on a flip chart page using the input of the group members.

Facilitate a discussion with the complete group concerning these following issues as they relate to each treatment resource listed:

- number of treatment slots available locally
- local demand for the modality
- degree of difficulty in obtaining service
- cost of modality
- length of modality
- eligibility criteria for modality
- potential for use as a treatment resource by TASC

Trainer Note: This list of issues can be put on a flipchart or an overhead for easy reference as you facilitate the above discussion.

45 Minutes

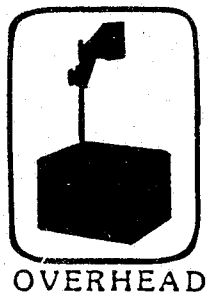
4. The Initiation of Treatment

Film -
The Intervention

In the previous activity you have assisted trainees in the development of a better understanding of substance treatment, the various modalities involved, and the availability of these modalities in their community. However, it is still a shallow understanding presented from the outside looking in. In this section you will show the Johnson Institute film, The Intervention, to provide trainees with a better understanding of how treatment works to confront the individual's addiction, how

treatment uses the family and critical events to assist in this confrontation, and how the process of recovery begins for the addicted person. The purpose of the film is to take the mystery out of substance abuse treatment and to demonstrate to trainees that treatment providers follow a proven effective plan to initiate the treatment process.

In setting up this film, clearly emphasize that **the film is not presented for the purpose of training TASC staff to conduct this intervention technique.** Rather, it is to demonstrate a means by which treatment may be initiated for a resistant client. Also, its purpose is to show that various methods are used to engage the client in the treatment process. TASC staff need to understand what goes on once a client is referred to a treatment program. This understanding helps TASC have a better working relationship with treatment providers. Display overhead 25 which sums up points made in the film.



OVERHEAD 25

intervention

DRUG DEPENDENCY AFFECTS THE CLIENT'S FAMILY, CO-WORKERS AND FRIENDS

SOME OF THESE INDIVIDUALS ENABLE CONTINUED ADDICTIVE BEHAVIOR, OTHERS STAND AND WATCH HELPLESSLY

THE FILM FOCUSES ON EARLY INTERVENTION

THE STRATEGY PRESENTED USES CONFRONTATION OF DENIAL

THE STRATEGY USES FAMILY, FRIENDS, EMPLOYERS, ETC.

THE EARLY INTERVENTION THEORY INVOLVES RAISING THE BOTTOM

CRIMINAL JUSTICE INVOLVEMENT OPENS CLIENT'S VULNERABILITY

TASC CAN PLAY ON THAT VULNERABILITY

Using the above overhead in introducing the film, cover the following points. Drug-dependency affects not only the specific individual but all those who touch his/her life. There are those who enable the individual to continue with their addictive behavior while others stand and watch helplessly.

In recent years, treatment of drug dependency has evolved to focus increasingly on early intervention. Intervention strategies used in treatment centers involve confronting denial of the problem early in the course of alcoholism or drug dependency. These strategies use family, friends, employers, and others to confront resistance to treatment. The theory involves "raising the bottom" countering the long held belief that a dependent person must reach bottom before they could be helped.

Criminal justice involvement often opens the drug dependent individual to a point of vulnerability that readies them to look at their problem for perhaps the first time. The TASC staff has the unique role of playing on that vulnerability, to remind the client where they might end up without treatment participation.

Resistance to treatment is often higher during the initial stages of treatment as the client is also dealing with issues of grief, guilt, and loss. Resistance issues in treatment must be recognized by the TASC case managers as they apply their intervention techniques.

Let's take a brief journey into substance abuse treatment. We're going to view The Intervention, a Johnson Institute film that demonstrates how the process of getting an impaired person to treatment is initiated and carried forth. Show the film The Intervention, which is 29 minutes long.

After the film has been shown, remind the group that its purpose was not to suggest that TASC duplicate this procedure, but was to sensitize them to a treatment oriented intervention. Now, facilitate a discussion using the following questions:

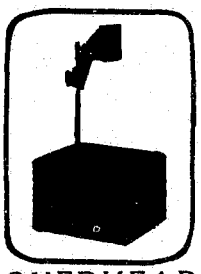
- What role does TASC play in intervention?
- What steps can TASC staff take to increase the likelihood that the intervention will result in a positive outcome for clients?
- How is TASC hindered in creating effective interventions?
- Is it possible for TASC to develop procedures to help ensure that its interventions are effective?
- What would be the components of a TASC intervention?

10 Minutes

5. Anticipating Barriers Between TASC and Treatment

Although many TASC workers may have treatment backgrounds, it is necessary to help them develop an understanding that TASC may be viewed suspiciously by treatment. This suspicion is created by a belief that TASC is aligned too closely with either the client or the criminal justice system. This section is designed to assist TASC workers in recognizing these barriers so that they can be understood and eliminated.

It is essential that TASC staff be aware of potential barriers that could exist between TASC and treatment. Overhead 26 highlights these potential barriers.



OVERHEAD
26

POTENTIAL BARRIERS

- UNDERSTANDING RESPECTIVE ROLES
- LANGUAGE AND JARGON WITHIN PROGRAM
- CONFLICTING GOALS FOR CLIENT
- CONFLICT OVER WHO THE PROGRAM SERVES
- CONFIDENTIALITY
- CONTROL OVER THE CLIENT
- STEREOTYPING OF PROFESSIONAL ORIENTATION

To maintain a clear TASC role and identity, barriers between systems need more than identification; they need to be understood and strategized.

One way to avoid hitting a barrier is to be clear on responsibilities. The TASC worker is not a counselor. You are not responsible for the client's wellness, but for the successful movement through the system.

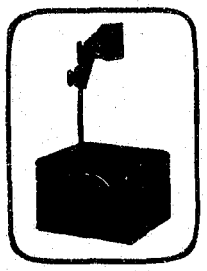
You must be clear on your responsibility. The TASC staff, above and beyond all else, is responsible to the justice system, to intervene in the addiction-incarceration cycle, and to provide assurances for community safety. TASC is then responsible to the treatment system to provide that bridge or access to justice in an objective manner. Then TASC has the responsibility to the client to see that their treatment needs are met.

Never argue with treatment counselors over therapeutics. The TASC role is an informational and supportive role. If continued problems develop with one treatment site, it might be best to search for another program to serve the TASC clients.

10 Minutes

6. Removing Barriers Between TASC and Treatment

Reflecting on the list of barriers that has been developed, have the group discuss means by which these potential barriers to good relationships between TASC and treatment may be removed. The means of removing these barriers include:



OVERHEAD 27

removing barriers

- ANTICIPATE PROBLEMS
- NEGOTIATE COOPERATIVE AGREEMENTS
- EVALUATE RELATIONSHIPS REGULARLY

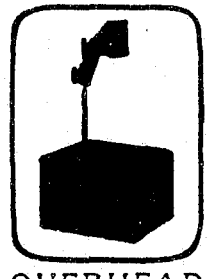
Ask the group how to go about removing barriers that have been identified? Be sure that each of the three barriers listed above is discussed.

15 Minutes

7. Development of Cooperative Agreements With Treatment

Included in the participant's manual is a sample cooperative agreement between TASC and treatment (pages 29-30). Allow participants time to review the agreement and then proceed as follows:

To be useful in removing barriers between TASC and treatment, cooperative agreements must address the issues we have identified. The example in the manual is representative of agreements used by TASC programs to formalize their relationships with treatment. You are encouraged to develop your local agreements in the form you see as most effective. The example is presented to provide participants some ideas. However, be sure agreements with treatment include references to the following (refer participants to page 28 in the participant manual):



OVERHEAD 28

TASC AGREES TO PROVIDE:

- intervention support
- assessment information
- case management services for the client
- reports to criminal justice authorities on client progress

TREATMENT AGREES TO PROVIDE:

- treatment slots for TASC clients
- intakes in a timely manner
- client progress reports
- notification to TASC of unresponsive participation
- immediate notification to TASC if client leaves residential program.

Ask the participants to look at the elements contained in the sample agreement. Facilitate a discussion around the fact that each element set forth helps them to do their job by establishing the boundaries within which they must work and defining their relationship with the treatment provider. See that each element is discussed. Allow them to add elements that they feel would be useful.

Solicit feedback from participants on the list above. Re-emphasize that greater specificity in cooperative agreements will eliminate barriers that are created out of lack of clarity of TASC's and treatment's roles in working with the client.

5 minutes

8. Module Summary

Use this period to review the elements of this session, briefly hitting on each of the following questions:

- What are the types of treatment modalities available in your community and where are the gaps in service?
- What issues do treatment providers have to deal with in attempting to initiate treatment with their clients?
- What are some potential problem areas that might become barriers to effective relationships between TASC and treatment?
- What are some ways to remove those potential barriers?
- How does an interagency cooperative agreement help to ensure good working relationships between TASC and treatment?

Close the session by stating that, in order to accomplish its mission, TASC must develop good working relationships with treatment providers. The more work done with treatment ahead of time and on an ongoing basis, the greater the effectiveness of the TASC worker and the easier his/her job. This is an ideal time to take a break.

MODULE VI:

CLIENT IDENTIFICATION AND SCREENING

TOTAL TIME: 2 hours 20 minutes

PURPOSE

This module is designed to provide a rationale for the development of clear client identification and screening protocols and to allow practice of skills in eligibility determination and screening.

OBJECTIVES

By the end of this session participants will be able to:

- Identify the three minimum eligibility criteria for use in any TASC program
- List four variables that must be addressed in developing eligibility criteria
- List six elements of a TASC screening interview
- Identify two issues that must be addressed in developing the screening interview document and format

MATERIALS/DOCUMENTS NEEDED

Overhead Projector
Overheads
Flipchart Stand/Paper
Markers
Prepared Scripts for Exercise

MODULE VI: CLIENT IDENTIFICATION AND SCREENING

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes **1. Client Eligibility**

Client identification and screening constitute the basic building blocks of effective TASC intervention. In this module it is your obligation to:

- Help participants see the importance of maintaining client eligibility criteria as a mechanism for supplying objectivity in determining who is and who is not appropriate for TASC services.

- Give participants the opportunity to practice determining client eligibility in a screening interview.

10 Minutes **2. Why Are Eligibility Criteria Necessary?**

Ask participants to recall the three minimum eligibility criteria common to all TASC programs.

- legal involvement
- drug involvement
- voluntary consent

Inform participants that these eligibility criteria will become the basis of what to look for in the identification and screening of potential clients. Inform participants that in addition to these criteria, there may be a need for additional criteria. Ask them why this is so. In the discussion be sure they cover the following points:

- need to limit client population/define target population
- assure that TASC does not duplicate existing services
- assure cooperation from justice system
- assure cooperation from treatment providers
- meet requirements of funding sources

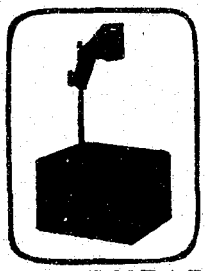
15 Minutes **3. The Process of Developing Eligibility Criteria**

You will need to prepare two flipcharts or overheads for this activity. The first overhead will identify whose input is needed in developing eligibility criteria and the second will outline the variables that must be discussed in developing criteria. The purpose of this activity is to inform participants that they must seek input in determining eligibility criteria and that they must reach agreement on the types of clients to be served by developing criteria that clearly include or exclude potential clients.

Inform participants (or ask them to determine) that there are two critical elements in developing eligibility criteria:

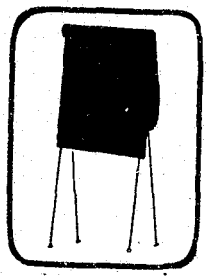
- determining who will be responsible for developing the criteria
- deciding what variables will be included in the criteria

Proceed to Overhead 29 and record suggestions from the group:



OVERHEAD 29

OR



FLIPCHART

WHOSE INPUT IS NEEDED ?

	√
√	√
√	√

Record responses on the chart. They should include:

- Judiciary - to ensure appropriate referrals, clear understanding and broad support of justice
- Corrections/Jail Personnel - for assistance in identification and access to potential TASC clients
- Treatment Providers - to ensure appropriate referrals to treatment, shared goals and expectations and broad support of treatment
- Community - to ensure community concerns and safety
- Police - to assist in early identification, to offer early intervention services and to develop support

You need to ask the participants why the input of these groups is needed. The appropriate response will indicate that if TASC is to be effective, there must be prior agreement by all elements of the criminal justice and treatment systems regarding the population to be served. If this agreement is not in place, TASC will suffer as a result of receiving referrals that it cannot service. This could result in a negative view of TASC on the part of the judiciary, treatment, and the community.

Now move to the next overhead. Ask the participants to describe the variables that must be considered in establishing eligibility criteria. On Overhead 30 display a list of these variables.

OVERHEAD 30

ELIGIBILITY VARIABLES

o CURRENT CHARGE	o LEGAL STATUS
o LOCAL RESIDENT	o PRESENTING PROBLEM
o LEGAL HISTORY	o TREATMENT HISTORY
o AGE	

Discuss each of the variables covering the following points:

- Current Charge - target populations that TASC will work with, e.g., violent offenders and misdemeanants not eligible
- Local Resident - provide full client services, will full case management be provided, and will treatment community accept
- Legal History - indicates drug use criminal activity, offender's potential for success, displays violent offenses that may rule out offender for TASC services.
- Legal Status - at what stage in criminal justice system will target population be serviced: pre-trial arrestee, probationer, parolee, etc.
- Presenting Problem - what is the presenting problem. In dual diagnosis cases, is substance abuse or mental illness the primary problem
- Treatment History - consider number of previous treatment failures that may indicate offender's poor prognosis for success. Conversely, consider the possibility that no previous treatment may indicate a good prognosis for success.
- Age - will target population be juvenile or adult. Are all TASC services available for each population

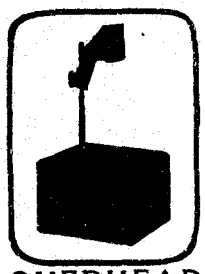
If the sites represented in the training have already developed eligibility criteria, compare site eligibility criteria with the variables just completed and discuss positive points with each.

Reiterate that each of these variables is an important factor in determining TASC client eligibility and must be agreed upon and understood by all system participants outlined in previous overhead.

10 Minutes **4. Client Identification**

Having determined the targeted TASC client population through eligibility criteria, you will now discuss how these eligible individuals are brought to the attention of TASC through client identification.

Explain the concept of identification as a methodology employed to bring potential TASC clients to the attention of TASC personnel. For example, building upon the relationships established with the criminal justice system, a procedure may be developed wherein the court clerk will refer offenders to the TASC office after noting a possession charge or previous treatment history. Overhead 31 lists methods for client identification. Refer to page 32 in the participant manual.



OVERHEAD
31

METHODS FOR CLIENT IDENTIFICATION

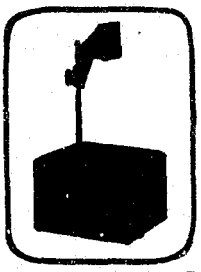
- ✓ REVIEW BOOKING LOGS, COURT DOCKETS
- ✓ DEVELOP RELATIONSHIPS WITH JAIL PERSONNEL TO HAVE THEM "THINK TASC" AND PROVIDE REFERRALS
- ✓ SET UP INFORMAL TASC ORIENTATION GROUPS IN THE JAIL OUTLINING
- ✓ PLACE TASC POSTERS IN POLICE STATIONS
- ✓ PROVIDE TASC PROGRAM INFORMATION TO THE LOCAL BAR ASSOCIATION

Discuss how identification methods tie in with target population and eligibility criteria. For example, if parolees are ineligible, you do not need to develop a method of referral from parole.

50 Minutes

5. Client Screening

Client screening is the method of applying the agreed upon eligibility criteria to the identified, potential client to further establish TASC eligibility. Describe the screening process as a two step process.



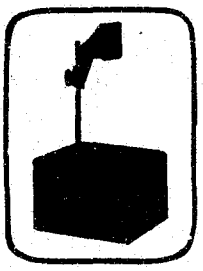
OVERHEAD
32

SCREENING PROCESS

1. COMPARE CLIENT WITH ELIGIBILITY CRITERIA TO DETERMINE IF SCREENING INTERVIEW WILL CONTINUE.
2. CONDUCT SCREENING INTERVIEW.

In discussing the issues presented in the above overhead, be sure to cover the following points:

- A review of client's current criminal justice involvement, drug use, and interest in tasc will suffice in gathering initial information and comparing it to the eligibility criteria. If you wish to include further site specific information for enhancement, such as age, income, or motivation, you may do so.
- The screening interview actually determines eligibility. Overhead 33 highlights what needs to be collected in the interview. Refer participants to page 33 in the participant manual.



OVERHEAD
33

ELEMENTS OF SCREENING INTERVIEW

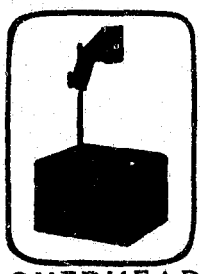
- DEMOGRAPHIC INFORMATION
- INTERVIEW INFORMATION: WHEN, WHERE
- ARREST DATA
- CURRENT LEGAL STATUS
- PRIOR ARREST DATA
- DRUG USE HISTORY
- DRUG ABUSE TREATMENT HISTORY
- EXPLANATION OF TASC SERVICES
- CLIENT'S CONSENT TO TASC SERVICES
- RELEASES OF INFORMATION
- SCREENER'S COMMENTS AND RECOMMENDATION
- SCREENER'S SIGNATURE

Certain essential information needs to be collected by the screener in the initial interview with a potential client.

- Basic identifying information: name, aliases, address, telephone number, date of birth, sex, ethnicity
- Interview information: date of interview, where interviewed (county detention facility, city jail,etc.)
- Present arrest data: nature of current charge(s), date of arrest, court dates, name of attorney, court of jurisdiction
- Prior arrest data: any pending cases, dates and charges of previous arrests, disposition of those cases, warrants pending
- Probation/parole status: charges, probation/parole officer's name, jurisdiction
- Previous drug or alcohol treatment experience: dates, name of program
- Previous TASC experience: dates, location of program, outcome
- Verification of information: source, comments
- Whether a person volunteered for TASC
- Screener's recommendation and comments
- Signature of screener

The purpose of screening is to collect just enough basic information to determine individual's eligibility and receptivity to TASC services.

Four considerations need to be explored regarding the screening process. These issues are included in Overhead 34. Refer participants to page 34 in the participant manual.



OVERHEAD
34

Screening Considerations...

- INFORMATION VERIFICATION
- CLEAR EXPLANATION OF TASC SERVICES
- SCREENING LOCATION
- CONFIDENTIALITY ASSURANCE

Now explain these screening considerations by covering the following points:

- Information Verification: the trained screener relies both on interview questions and answers (with verification of key points) and observation of the arrestee's appearance and conduct. To verify interview information, the screener may:

  - talk with a family member or other significant person
  - talk with a probation/parole officer
  - check prior treatment record, talk with treatment counselor
  - review previous TASC files, if any
  - talk with arresting officer
  - review criminal record
  - review information collected by other pretrial agencies

- Clear explanation of TASC services: This is essential. During screening, TASC staff should explain both the benefits and requirements of TASC participation, which might include:

  Benefits

  - May facilitate release from jail.
  - May facilitate entry into a treatment program.
  - May provide TASC letter or representative at all court appearances.

  Requirements

  - Regular attendance at the assigned treatment program.
  - Satisfactory/regular urine drug screening results.
  - Avoidance of criminal behavior.

- Screening Location - TASC should take the initiative to find eligible clients. screening staff may need to conduct interviews wherever the potential clients are best accessed. Typically, this will be accomplished in a jail or detention facility, the TASC office, or at court. Regardless of where the interview takes place, the process and information to be collected is the same. Procedures, however, may need to be varied to fit the particular environment. Usually, the TASC office will be the most comfortable for both the client and the staff person. Courtroom screening may be more confusing

and hurried if the judge is waiting for immediate feedback on eligibility. In-jail screening can be difficult because of crowding and security issues, although jail is the most usual screening setting. Regardless of where screening takes place, screening staff should be mindful that the environment does not work against their need to make careful, rational decisions regarding client eligibility.

Conducting a screening interview in a correctional setting such as in a jail or a courthouse holding cell has obvious drawbacks: the interview site is not conducive to creating a relaxed atmosphere, and there usually very little privacy. Also, the client is under emotional stress and is usually distrustful of the interviewer. In addition, certain civil liberties issues mentioned earlier must be kept in mind. If at all possible, TASC staff should try to obtain a small office or interview room in which to conduct screening interviews.

- Confidentiality Assurance: Confidentiality and other legal considerations are an essential component of screening. If after the initial interview it appears that an individual who volunteers for the program is eligible, the screener should obtain the volunteer's signature on the appropriate consent form for release of confidential information. Further, since the initial TASC contact with an arrestee may occur shortly after arrest and before an attorney has been consulted or the arrestee has appeared in court, the screener must take care that no rights are violated. The arrestee should not be coerced into participating in the interview, should be informed that he/she need not answer, and should be told the information given is confidential under Federal law, cannot disclosed without written consent or as provided by that law, and cannot be used for prosecution or criminal investigation purposes.

Summarize this section by reviewing the two stages of screening.

Trainer Note: Remember throughout the previous discussion, the trainer needs to be sensitive to the local eligibility criteria while reinforcing the minimal criteria proposed in this course.

40 Minutes

6. A Simulated Screening Interview

The final activity in this module is a fishbowl activity where participants will volunteer to play the roles of a TASC screener and a newly arrested individual being held in a county jail. Depending upon the size of the training group you may decide to have only one fishbowl or several. The optimal group size is 6-8. Be sure that no one sees the scripts for the TASC screener or potential client except the people playing those roles.

TRAINER NOTE: For maximum effectiveness, the TASC screener and potential client (Max Johnson) volunteers should be pre-selected and briefed by you prior to the role play. The scripts for both are at the end of this module. Duplicate the scripts in advance of this exercise.

Once you have set the stage for the role play, have the screener interview Max Johnson. Allow twenty minutes for the interview. Instruct the observers to watch the interview and jot down their observations about the interview process. Call time at the end and process the role play by asking the following questions.

To the group:

- How effective was the screener in obtaining information from Max Johnson?
- Do you believe Johnson was always telling the truth?
- Is Max Johnson a good candidate for TASC services?
- Did Johnson attempt to manipulate the screener?
- Did the screener establish a rapport?
- Was there any discussion of confidentiality

To Max Johnson:

- Were you truly motivated to get help for a drug problem?
- How did you perceive the TASC screener?

To The TASC screener:

- Is Max Johnson appropriate for TASC services?
- Do you feel he gave you honest responses?
- How can you tell when you're being lied to?

10 Minutes **7. Module Summary**

Summarize the module by asking the following questions. Be sure to solicit resources from a variety of participants.

- Why are eligibility criteria necessary?
- What information should be obtained in a screening interview?
- Are all clients motivated to use TASC as a means of dealing with their substance abuse problems?

Close the session by stating that screening is an imprecise science because of potential manipulation by clients. However, the process of verifying information assists in further determining who is ultimately appropriate for services. In the next module we will be reviewing the process of assessing the client's treatment needs and developing a treatment recommendation. This would be an ideal time to take a break.

CLIENT SCRIPT

You are Max Johnson. You are male, age 24. You have been arrested six times previously: possession of marijuana, burglary, grand theft, petty theft, possession of marijuana, disorderly conduct.

Your current drug use consists of cocaine, either snorted or smoked one to three times a week, daily use of alcohol (in excess of four cans of beer), and no history of opiate abuse. You have never been through detoxification and have never been involved in substance abuse counseling. You perceive of yourself as a person who profits from drugs through sales.

You have been unemployed for the past two years but have survived reasonably well by selling pot and, more recently, crack. You were arrested inside a local business Friday night when you tripped a silent alarm. The cops found a vial with crack residue in your pocket. You were a little high when arrested.

If you could get a message to your aunt she would surely put up the $1,500 cash and collateral to get you out of jail, but she doesn't have a phone. You figure that TASC will make contact with her. Possibly the TASC screener could drive by her house on his way back into town.

You're also angry that the cop threw you down on the floor in the store after you raised your hand and screamed - "Don't shoot". He called you a punk and kicked you twice in the side. You want to get back at that guy somehow.

You left a gun and a wad of cash behind a loose brick in the foundation of your aunt's house and you'd like to get that money before someone else finds it. Maybe if you make yourself seem real interested in drug treatment, TASC will help get you out. Exaggerating your drug use might help, even though you're into drugs for money, not because you're strung out like some of those other crack monsters out on the street.

SCREENER SCRIPT:

When you told the guard you wanted to see Max Johnson, he said, "Oh man, is he in here again? He's no good at all. Don't trust that man, he'll sell you a bill of goods a mile long."

You represent a TASC program that has a good relationship with the courts in securing the release of pretrial inmates who appear to present a good risk to appear for trial. Your review of Johnson's record indicates that although he has a number of arrests, he has always appeared in court when scheduled. He has lived in the community since birth.

You've decided that because of his local background, no history of crime involving weapons, and the nature of his charges that he would potentially be eligible to apply for TASC.

MODULE VII: ASSESSMENT AND REFERRAL

TOTAL TIME: 1 hour 55 minutes

PURPOSE

This module is designed to provide participants with the tools to conduct an assessment of the client's needs and an understanding of the mechanics of matching treatment needs with available treatment.

OBJECTIVE

By the end of this session participants will be able to:

- Define five terms related to assessment and referral
- List six of the eleven critical components of an assessment
- Conduct a client assessment employing at least six of the eleven critical components
- Develop a treatment recommendation based on case scenarios

MATERIALS/DOCUMENTS NEEDED

Overhead Projector
Overheads
Markers
Participant Manuals

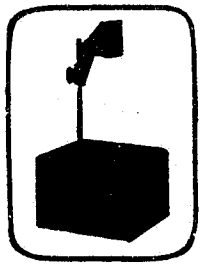
MODULE VII: ASSESSMENT AND REFERRAL

TIME/MEDIA & MATERIALS:	outline of training activities

10 Minutes **1. Introductions - Definitions**

This module will identify necessary information to be gathered to determine the client's appropriateness for treatment and recommended treatment modality. In an effort to provide the group with a common language the following exercise should be completed.

Using Overhead 35, present the list of the five terms and ask the audience to define each term. You should record and discuss each definition provided.



OVERHEAD 35

terms---

- ASSESSMENT
- PSYCHO-SOCIAL HISTORY
- MOTIVATION
- DIAGNOSIS
- REFERRAL

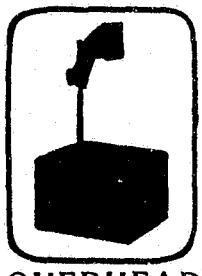
Once you have listed these terms, ask the group to identify any differences from the definitions contained on page 36 in the participant manual.

- Assessment - formal process of collecting client information in order to make recommendations for behavior change.
- Psycho-Social History - a collection of historical information including client's social functioning and mental health status.
- Motivation - desire to act or change.
- Diagnosis - the labeling of a set of client attributes/symptoms.
- Referral - the act of recommending an individual to a specified treatment regimen.

These terms provide the foundation for the TASC activities of assessment and referral.

15 minutes **2. Assessment Interview Process.**

Display Overhead 36 which lists the steps in the assessment interview process.



OVERHEAD 36

ASSESSMENT INTERVIEW

A. PREPARATION
B. INTRODUCTORY STAGE
C. DEVELOPMENT STAGE
D. TERMINATION STAGE

Now explain each stage by highlighting the following points:

- Preparation Stage - Prepare for the interview by reviewing existing data on the client including screening data already gathered. Note any areas where you believe validation will be necessary.

- Introductory Stage - Begin to establish rapport with the client by explaining the type of information you are seeking, reasons for conducting the interview, confidentiality issues, and the information that will be presented to the criminal justice system and to treatment. A genuine, courteous, personal introduction should precede these initial steps, and efforts should be made to clarify the role of the interviewer. Expectations of the client's role in the process should also be made clear. The interviewer is listening and observing from the first moments of contact with the client.

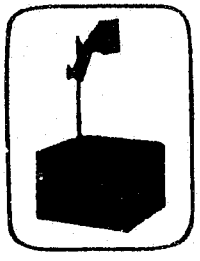
- Development Stage - First obtain from the client less threatening or sensitive information. Continue developing rapport with the client, gradually testing the limits until all data is collected and impressions are formulated. Questioning techniques may include the following approaches:

  - closed: asking questions that evoke a yes or no response

  - open: general questions that require a more lengthy response in which client must formulate and relay concepts, ideas, events, etc.

- probing: questions that are designed to test defensiveness, evasiveness and other tactics to avoid significant self disclosure to the interviewer.

The interviewer must pay attention to whether the client's responses are entirely on a feeling (emotional) level, content only level (facts devoid of feelings), or a blend of both. The posture the interviewer should take is one that avoids judging, moralizing; denying feelings, arguing, lecturing; giving advice and solutions; playing psychiatrist, over-interpreting; digressing, storytelling; and loss of control in the interview process. Display Overhead 37 to emphasize these issues.



OVERHEAD 37

AVOID -

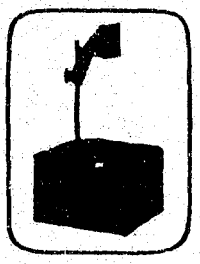
- JUDGING, MORALIZING
- DENYING FEELINGS, ARGUING, LECTURING
- GIVING ADVICE, SOLUTIONS
- PLAYING PSYCHIATRIST, OVER INTERPRETING
- DIGRESSING, STORYTELLING
- LACK OF PERSONAL BIAS, INTERVIEW CONTROL

Be sure to explain each of the above terms to the participants. Ask for any questions or clarifications.

- The Termination Stage - Continue to maintain the rapport already developed by closing out the interview in a way that leaves the client feeling comfortable about the experience. The information is now gathered; therefore, be sure to clarify, fill in gaps, reflect on your impressions, and tell the client what to expect next in the process. Discuss any appropriate, unanswered questions the client may have.

20 minutes **3. Elements of A TASC Assessment**

For the purpose of this training, participants will be exposed to an assessment format consisting of 11 areas:

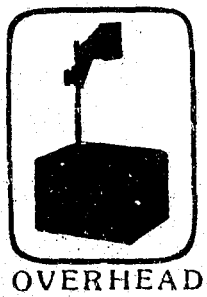


OVERHEAD 38

TASC ASSESSMENT

1. Drug History
2. Criminal History
3. Mental Health History/Status
4. Treatment History
5. Family History
6. Personal History
7. Educational History
8. Employment History
9. Medical History
10. Support Systems Review
11. Summary and Treatment Recommendations

Below is a summary of the information that should be shared with participants regarding the 11 elements. This information is included in pages 38-39 of the participant's manual. Display overheads 39 and 40 to aid in the discussion.



OVERHEAD 39

1- DRUG HISTORY

- frequency, intensity, duration
- primary drug(s) of abuse
- evidence of dependency

2- CRIMINAL HISTORY

- number and nature of prior arrests violence
- current legal status and actors
- history of failure to appear, escape, violation of probation, etc.

3- MENTAL HEALTH HISTORY/STATUS

- orientation to person, place, time situation
- ability to concentrate on interview process
- appropriateness of response

4- TREATMENT HISTORY INCLUDING SUBSTANCE ABUSE HISTORY

- number and type of prior treatment experiences
- treatment outcome, including length of abstinence, post treatment
- nature of referral to treatment - voluntary, civil commitment, criminal commitment
- suicide attempts, number, circumstances

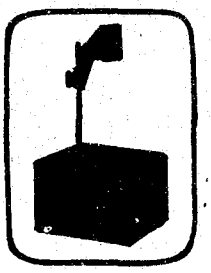
OVERHEAD 39

continued next page

OVERHEAD 39
continued

5- FAMILY HISTORY

- history of neglect, abuse, criminality by parents, siblings, children
- history of substance abuse by parents, siblings, children
- history of psychiatric disorders within family unit



OVERHEAD 40

6- PERSONAL HISTORY

- childhood development, raised by whom
- client's assessment of critical life events: i.e., marriage, school dropout, onset of substance use, etc.

7- EDUCATIONAL HISTORY

- highest grade completed, vocational training
- reason for leaving school
- adjustment problems, learning disabilities

8- EMPLOYMENT HISTORY

- number and type of jobs held during past five years
- job skills, training
- attitudes toward work
- veteran status, type of discharge, benefits

9- MEDICAL HISTORY

- treatment for substance overdose or detoxification
- AIDS risk assessment: sexual orientation, needle sharing, multiple sex partners
- brief medical history
- family treatment, high blood pressure, heart disease, cancer, etc.

10- POSITIVE SUPPORT SYSTEMS

- peer members
- employment
- community involvement

11- SUMMARY AND TREATMENT RECOMMENDATIONS:

- summary of diagnostic information that leads you to a treatment recommendation

Be sure to include additional ideas under each step as they are provided by participants.

35 minutes **5. Assessment Exercise**

Inform participants that they will now be conducting on assessment of an individual using the 11 topic format. Participants can observe and fill out the assessment document on pages 40-41 in their manuals. Two trainers are required to facilitate this activity. One trainer will assume the role of the client to be assessed while the other trainer will guide the activity. Two scripts are presented at the end of this module. Either script which can be used by trainers, depending on gender desired.

Trainer Note: Trainers may wish to include additional history and characteristics they believe will assist in creating a realistic case history.

Lead trainer will inform participants that they will be conducting a group assessment of a TASC client. The group will have 20 minutes to interview the client. Refer participants to the assessment document included on pages 40-41 in their manuals. Lead trainer will select a participant to begin the interview and then periodically move to another participant in sufficient time to assure that all or most participants have an opportunity to take part in the assessment.

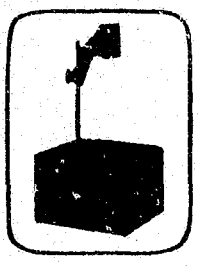
The lead trainer should be taking notes regarding participants' strengths and weaknesses in interviewing, including their ability to establish rapport, ask certain types of questions, understand the topics in the assessment, etc. This feedback should be provided at the end of the 20 minute assessment period.

Also solicit participant feedback on the assessment. Ask them what went well with the assessment process and what were the difficult areas that seemed to surface. Finally, the trainer who portrayed the client should inform participants of the material in his/her role that the interviewers did not obtain during the interview. The trainer should also note how the participants might have rephrased questions in order to obtain that information.

20 minutes **6. Developing a Recommendation:**

The assessment process culminates in a review of the assessment data with the identification of treatment needs and the development of a treatment recommendation. The process involves a listing of services that a client requires and identification of topics to be addressed during treatment. This should <u>not</u> be viewed as a treatment plan that outlines the specific goals and objectives of treatment. That is developed by the treatment counselor.

Using the overhead projector, the trainer should emphasize each of the four points identified for developing a recommendation. The most prominent factors to be considered when developing a recommendation and selecting a program are:



OVERHEAD
41

Making A Recommendation

- ☐ PRIOR TREATMENT EXPERIENCE
- ☐ INTENSITY, FREQUENCY, DURATION, AND TYPE OF DRUGS USED
- ☐ AVAILABILITY OF TREATMENT
- ☐ THE SCREENING INTERVIEWER'S RECOMMENDATION

In referral, TASC staff must remember that they serve the needs of four "clients."

- the criminal justice system
- the treatment system
- the community
- the offender

The interests of all four groups should be strongly considered in developing a recommendation. Case staffing for recommendations is a helpful way to ensure that all interests, factors, and implications are considered and balanced in the process.

Refer participants to the assessment they have just completed. Using the information obtained, ask them to break into groups of five to develop a treatment recommendation. Allow ten minutes for the groups to reach consensus on a recommendation. Now provide an opportunity for each group to report their results. Be sure to discuss any issues or discrepancies that surface from the small group reports.

10 Minutes

7. The Referral Process: Discussion

The purpose of referral is to arrange for the client's entry into treatment. Referral staff should distinguish between the client's primary needs and need for ancillary/support services. The primary referrals discussed in this module are to substance abuse treatment facilities. Secondary referral, however, might be made to meet some other identified needs (vocational rehabilitation, food stamps, housing, etc.) Each program should determine whether ancillary referral responsibilities are delegated to TASC (and which staff) or to the treatment facility.

Trainer should explore with participants how primary and secondary referral is actually delegated in their program. The group should identify the required information and necessary steps in making an appropriate referral.

Use the following overhead, also included as page 42 in the participant's manual, to review referral issues.

OVERHEAD 42

REFERRAL ISSUES

- KNOWLEDGE OF AVAILABLE TREATMENT RESOURCES
- ADMISSION CRITERIA OF TREATMENT PROGRAMS
- COST OF TREATMENT
- CONTACTS AT TREATMENT
- DESCRIPTION OF PROGRAM ACTIVITIES,
- RULES FOR THE CLIENT

Discuss each of the five referral issues highlighting the following points:

- Knowledge of available treatment resources - how aware are TASC staff of the variety of substance abuse treatment in their community. What modalities and what services are available: individual, group, family counseling; substance abuse education; methadone; ancillary services such as vocational rehabilitation, medical and dental services, legal assistance, housing and transportation.

- Admission Criteria - what are the restrictions as to age, sex, residency, drug of abuse, length of addiction, financial status, legal charges

- Costs - entrance fees, scaled fees as to ability to pay, ability to bill insurance (commercial insurance, Veterans Administration, Champus, Medicaid, etc.)

- Contacts at Treatment - whom to contact, how appointment will be made

- Description of Program - where facility is located - address, phone number, maps or directions; what client should bring; what client should expect on arrival; program hours and knowledge of any special intake hours; whether client will be escorted to the facility

5 minutes

8. Module Summary

Summarize the module by pointing out that a good TASC assessment is an integral step toward assuring the success of the client in whatever type of treatment he/she enters. A thorough assessment points to the appropriate treatment referral and sets the stage for the case management plan.

Finish by reviewing the module objectives. Clarify any issues or questions remaining about the TASC assessment and referral process. A break is in order at this time.

Script #1

GARY JONES

Male, mid-30's, long history of drug abuse, particularly opiates, cocaine, and alcohol. Divorced twice, with two children from first marriage and one from second. Both ex-wives live in area, second wife is currently a TASC client in outpatient drug treatment.

Gary is currently using cocaine, codeine and occasionally valium. He is now in the county jail charged with strong arm robbery stemming from purse snatching. Gary has lengthy history of arrests, primarily possession charges, but also grand theft and simple battery charges. He has been on probation for sale and delivery of cocaine.

He has recently experienced a religious conversion in jail and is attending all church services as well as AA and GED classes.

Gary is bi-sexual and is currently having sexual relationships with other prisoners, resulting in his being placed in segregation for three days.

Gary has been in several treatment programs, both inpatient and outpatient. He was abstinent from cocaine and codeine at one point for 18 months. He was kicked out of one residential program for using alcohol and has never abstained from alcohol outside treatment.

For the past two weeks Gary has been experiencing daily diarrhea. During the past week he reported noticing heavy sweating during the night.

Script #2

JOAN REGAN

Female, age 19, one child, age 18 months, currently lives with her mother and two younger sisters, ages 16 and 9. Her father died of liver and kidney ailments at age 49. Currently on a pre-trial diversion program after an arrest for uttering a forged instrument involving writing three checks on her mother's checking account totaling $486.00. She has no prior arrest record.

About nine months ago Joan attempted suicide by cutting her wrists in the bathroom of her home while her mother and older sister were there. The wounds were not life threatening, but she was admitted to a psychiatric unit and discharged later on anti depressants. She subsequently was scheduled to see a mental health counselor, but never appeared.

Joan's mother reported her to social service authorities about four months ago when she came home, found Joan drunk and the baby wandering in the front yard near the street. The child is now in foster care.

Joan has been using alcohol and marijuana since age 12. She currently uses alcohol and marijuana daily and has recently been smoking PCP laced joints with her boyfriend of six weeks. She was fired from her job as a hotel maid last week after being accused of taking money from a guest's room. No charges were filed.

She has not had substance abuse treatment in the past. She has been referred to TASC as part of her pre-trial intervention agreement.

MODULE VIII: CASE MANAGEMENT

TOTAL TIME: 2 hours 30 minutes

PURPOSE

The purpose of this module is to communicate the basic methods of effective and efficient tracking and case management of the client's progress through the treatment system including accurate and timely reporting to the justice referral source.

OBJECTIVES

By the end of this module participants will be able to:

- Identify at least three case management functions
- Define the terms case conference and jeopardy status
- Write a client progress report that contains at least 60% of the required reporting elements
- Provide at least three examples of information that will assist the court in case disposition

MATERIALS/DOCUMENTS NEEDED

Flipchart Stand/Paper
Case Examples
Markers
Overhead Projector
Overheads

MODULE VIII: CASE MANAGEMENT

TIME/MEDIA & MATERIALS:	outline of training activities

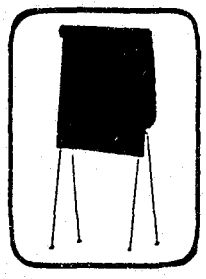
5 Minutes **1. Case Management Overview**

You should review all of the following information regarding the role and function of a TASC case manager. Once the client is accepted into TASC, the TASC case management function begins. Through case management the linkages previously established with the justice system are heightened and the treatment partnership is facilitated.

The case manager is responsible for upholding the TASC programs success/failure criteria and therefore assuring client progress through the treatment continuum to a satisfactory end. The case manager must be aware of "flags" that may signal impending client failure. This ensures TASC program credibility to both the criminal justice and treatment systems.

30 Minutes **2. Success/Failure Criteria**

The purpose of this section is to help participants understand the need for success/failure criteria and the importance of applying this criteria consistently to all TASC clients. Make the point that the programs success/failure criteria is what it will use to measure the effectiveness of the TASC intervention.



FLIPCHART

Now divide the participants into groups of five. Distribute to each group a piece of flip chart paper and a marker. Ask half the groups to create a list of success criteria for TASC clients. How will you know if a client has been successful in TASC? Ask the other group to create a list of failure criteria for TASC. How will one know if a client has been unsuccessful in the TASC program? Ask the groups to be specific in their lists. For example how many positive urines in what time period can a client have before being terminated unsuccessfully from TASC. Suggest group members work towards consensus on a point before they put in on their list. Allow approximately 15 minutes for this task.

Once the lists have been created, ask a spokesperson from each group to report out the groups recommended success or failure criteria. After each individual has reported ask the larger group if they have any questions or need clarification. Be sure to question any criteria that are unclear or aren't specific. Repeat this process until all of the participants have reported.

Summarize this exercise by making the following points:

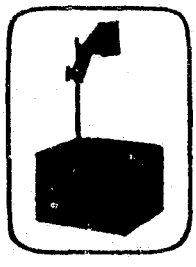
- success/failure criteria allow the program to measure the effectiveness of their interventions
- success criteria provide the client a goal they can strive for
- failure criteria provide the client real clear parameters of what behavior is acceptable to remain in the TASC program
- success criteria should include length of time on the program, completion of treatment, no new criminal activity and length of time drug free as reflected in clean urinalysis results
- at a minimum, failure criteria present what a client will be terminated for: continued drug use as evidenced by positive urine screens; a specific number of unexcused absences from treatment; further criminal justice involvement, to the extent that guilt has been determined; a documented, consistent failure to participate in treatment; and a documented, consistent lack of cooperation with the TASC program.
- the success/failure criteria needs to be applied consistently to all clients. This will ensure the integrity of the TASC process and credibility with the criminal justice and treatment systems

15 minutes

3. Elements of Case Management

The essential elements of case management consist of five key functions: assessment, planning, linking, monitoring, and advocacy. Using overhead 42, display those five elements and refer the group to page 44 in the participant manual.

Trainer Note: The term "assessment" in case management must not be confused with the treatment assessment definition given in the previous module.



OVERHEAD 43

CASE MANAGEMENT SERVICES

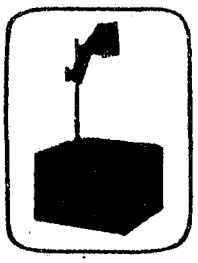
- ✘ Assessment
- ✘ Planning
- ✘ Linking
- ✘ Monitoring
- ✘ Advocacy

Now, discuss each element in detail, using the overheads provided.

OVERHEAD 44

assessment

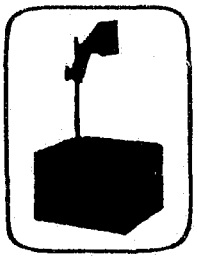
- Determining strengths, weaknesses, and needs
- Evaluating the clients ability to remain drug free within the constraints of their social and treatment environments
- Synthesizing information obtained from prior assessments conducted by TASC screeners, as well as other medical records obtained in the intake process
- Ensuring the development of an overall case plan that addresses the general needs of the client.



OVERHEAD 45

planning

- The case plan is concerned with the progression of services to be provided over time.
- Treatment issues - the case management plan should highlight the treatment services anticipated and ancillary services needed.
- Criminal justice issues- ensuring client appears for court hearings and/or develops a regular schedule of contacts with the responsible criminal justice official, e.g., probation officer.
- There may be several personalized treatment plans that are used by treatment providers, but there is only one TASC case plan that gives an overview of all services being provided to the client.



OVERHEAD 46

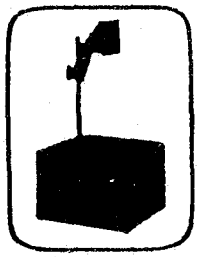
linking

- The process of taking or sending individuals to any required service: treatment, legal, or ancillary.
- Assuring continuity when the client moves from one component to another in any system, i.e., from custody to a treatment provider or from a pretrial status to probation.
- The case manager is the constant link between the client and numerous other systems involved in the rehabilitation process.

OVERHEAD 47

monitoring

- Continuous observation of an individual's progress in treatment, which leads to continuous reassessment and the development of new plans, linkages or disposition.
- Application of success/failure criteria to the individual's progress.
- Regular reporting of offender's progress in treatment.



OVERHEAD 48

advocacy

- Interceding on behalf of the client to assure equity. There are two forms of advocacy:
  - Case specific advocacy: influencing treatment and ancillary services to respond to the client's needs.
  - Class specific advocacy: influencing treatment to change in response to documented deficiencies in the system.

Operationally, the case manager is responsible for: disseminating information to all systems regarding the client, knowing the clients whereabouts at all times; monitor the client's participation with respect to the established success/failure criteria; regularly reporting the client's progress or lack of progress to the justice referral source; providing ancillary referral services to the client as needed; and objectively assisting the court in reaching a final disposition on the client.

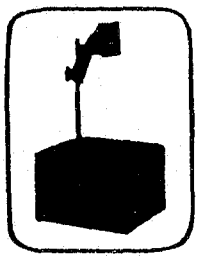
When the client enters the case management phase of TASC, the case manager must make immediate contact to ensure the client is oriented to TASC, to the treatment facility and to the criminal justice mandate. Also the case manager is responsible to orient the treatment staff to the particular client, ancillary linkages or referrals needed or advocacy planned; and reiteration of TASC's expectations of treatment regarding the client.

20 Minutes

4. Quality Case Management

Now facilitate a discussion of specific factors that affect the quality of case management. Overhead 49 lists four such factors.

Ask the group to suggest other possible factors and list these on the overhead. This information is found on page 46 of the participant manual.



OVERHEAD 49

Factors Affecting Quality Case Management

CASELOAD

OFFICE LOCATION

DECISION MAKING POWER DELEGATED TO CASE MANAGER

ACCESSIBILITY AND AVAILABILITY OF TREATMENT SERVICES

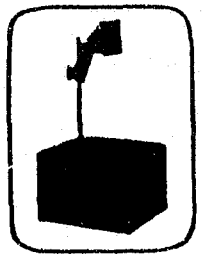
Once you have developed the list, divide the participants into groups of three and ask them to discuss how each term on the list may affect the quality of case management services. Allow 10-15 minutes for this task depending on how many items are on the list.

Now facilitate a large group discussion regarding factors that affect the quality of case management. Take each item on the list and ask for comments on why that particular item might affect quality services. Summarize how these factors can have a negative affect on the delivery of case management services. Point out why it is necessary to deal with these issues in order to ensure effective operation of the case management function.

15 Minutes

5. The Case Management Continuum

Present the fact that case management services can be viewed on a continuum. The continuum begins with the acceptance of the client into TASC and is not complete until the client has been terminated either successfully or unsuccessfully from TASC. Present to the participants the case management continuum as illustrated in overhead 49 and found on page 47 of the participant manual.



OVERHEAD 50

case management continuum

Client accepted into TASC
Client placed into treatment
Maintaining success/failure criteria
Identifying "flags" that may signal client failure
Monitoring progress/behavior
Reporting progress to courts
Providing ancillary referral services
Assisting the court in final disposition
Client Terminated

Review each phase of the continuum discussing issues that must be considered regarding each phase. Be sure to cover the following points:

- Accepting the Client Into TASC - Be sure the assessment is completed and the client fits the TASC programs eligibility criteria. If not, be sure it is documented why the program accepted the client, i.e. special request from presiding judge.

- Facilitating Placement of Client Into Treatment - Follow the assessment recommendation for placing client into treatment, make sure the client actually showed up for the initial treatment appointment.

- Maintaining Success/Failure Criteria - Follow the programs established success/failure criteria. Consistently use the criteria with all clients.

- Identifying "flags" that may signal client failure - Look for problems that may develop with the clients participation: missed appointments, positive urinalysis, changes in residence, new criminal charges. Bring any problem behavior to the attention of the client immediately.

- Monitoring Client Progress/Behavior - Set up an individual plan of action to track each clients participation in TASC. Monitor treatment appointments, employment, urinalysis and court appearances.

- Reporting Progress to Courts - Set up a mechanism to report status of client to the appropriate criminal justice authority following an agreed upon timeframe. This timeframe should be that agreed upon in the letters of agreement with criminal justice agencies.

- Providing Ancillary Referrals - For many clients to be successful, they are in need of additional help and services. The case manager needs to develop contacts and a system of referral to assist clients in getting housing, veterans benefits, food stamps, vocational services, education and similar services.

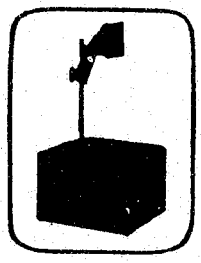
- Assisting Court in Final Disposition - The case manager reports regularly the clients progress to the court. In a termination, violation or similar hearing the TASC case manager may have to testify regarding the clients participation in the TASC program.

- Client Termination - Terminating the client from TASC either successfully or unsuccessfully. Documentation of the termination status is essential.

15 Minutes

6. Monitoring Issues

This section will present the issues a case manager needs to be in tune with in order to make the case management process as effective as possible. Overhead 51 displays the monitoring issues that are key to effective case management services.



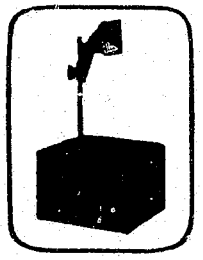
OVERHEAD 51

monitoring issues

- TASC CLIENT ORIENTATION
- CONTACT WITH CASELOAD
- REPORTING
- UNSUCCESSFUL TERMINATION
- SUCCESSFUL TERMINATION
- TERMINATION FROM TREATMENT, NOT FROM TASC

Discuss each of these issues highlighting the following points:

- Client Orientation - the first step in the monitoring process is to be sure the client clearly understands what is expected of them as a TASC client. The case manager needs to provide an orientation to the new client highlighting what is TASC, the program rules, expectations for performance and criteria for successful participation. Some of the key elements necessary to discuss during the orientation of the new client to the TASC program are:



OVERHEAD 52

TASC client orientation

WHAT IS TASC
TREATMENT PROGRAM REQUIREMENTS
JUSTICE REQUIREMENTS
THE CASE MANAGEMENT PLAN
URINALYSIS REQUIREMENTS
ANCILLARY LINKAGES PLANNED
OTHER REFERRAL NEEDS
PROGRAM EXPECTATIONS: DO'S AND DON'TS

- Contact with Client Caseload - TASC case managers must see each client regularly. Residential clients, because they are housed within a facility at all times, are more accessible than are clients in outpatient treatment, but consistent, regular contact for both client types is essential. If a client does fail in TASC, regular monitoring of his or her performance, assures the greatest amount of credibility.

- Reporting - The case manager should regularly report the client's progress or lack of progress to the justice referral source. Reports must include:

  - client entry into the treatment process within a specified time frame

  - client's progress or lack of progress in treatment defined by attendance, urinalysis results, interaction with peers and treatment staff, further justice involvement

  - immediate notification of client's unsuccessful termination

  The monthly progress report is the main tool for keeping the criminal justice system updated on the clients progress or lack of progress in treatment. A thorough monthly report should include a report on:

  - attendance
  - urinalysis results
  - interaction with peers and treatment
  - further justice involvement

  Discuss each of these items pointing out why this data is essential. Also point out the importance of reporting objective data and how this adds to the credibility of the case management process.

  Refer participants to page 49 in their manuals where an example of a monthly progress report is displayed.

  Remind participants of their need to field test their monthly report documents with criminal justice officials who will be receiving the reports for relevance and suitability to their needs.

  TASC projects should report monthly to criminal justice on client progress and notify criminal justice within 24 hours of negative termination from TASC.

- Unsuccessful Termination - A standard unsuccessful terminate procedure would be as follows. If a client violates one or more of TASC's monitoring criteria, he/she will be unsuccessfully terminated from TASC. The TASC case manager will immediately notify the judicial personnel by telephone and prepare a report within 72 hours of the determination. The report will briefly summarize in chronological order the objective facts of the client's treatment experience, TASC's monitoring and intervention strategies, and the reason for discharge.

  When a client fails to fulfill a treatment mandate via TASC, the TASC case manager will testify in court at a scheduled violation hearing. TASC's role at such a hearing is to present objectively the facts of the client's behavior leading to the unsuccessful termination, all in accordance with TASC monitoring criteria.

  Before the scheduled violation hearing, the TASC case manager will review the client's file and be thoroughly familiar with all the facts of the client's treatment records. Before the scheduled violation hearing begins, the TASC case manager will prepare sufficient copies of the written termination report to enable all judicial personnel to have available the TASC documentation at the time of the violation proceedings.

  At all times testimony provided by the TASC case manager during the violation proceedings must be in keeping with TASC's role to provide only objective data. In chronological order, the TASC case manager should present the facts of the client's treatment record as monitored by TASC and the facts of TASC's efforts to intervene in the client's failure to make satisfactory treatment progress (when applicable).

- Successful Termination - A successful termination procedure would be as follows. When a client has successfully met all requirements for treatment rehabilitation with TASC in fulfillment of a court mandate, the TASC case manager will get in touch with the judge for the purpose of amending the client's jurisdiction conditions before his/her termination from TASC.

  Before contacting the judge, the TASC case manager will prepare the appropriate written report. In court, he/she will verbally discuss the client's status with TASC in accordance with TASC criteria for monitoring treatment progress and explain TASC's determination that the client has satisfactorily met the court's conditions and has successfully completed drug treatment.

  The TASC case manager is responsible for contacting the judge before the discharge date proposed by the treatment facility.

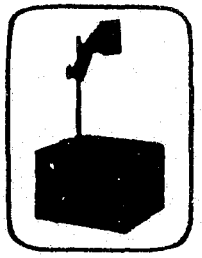
- Termination from Treatment, not from TASC - On occasion clients may find themselves unsuccessfully terminated from treatment without violating TASC criteria. Some treatment rules are not important to the justice system and therefore TASC will re-refer the client, while notifying the court of the termination and change of treatment status.

  An example of this would be if a client was caught embracing another client. Because this act is often against the treatment rules of a residential program, the client will be terminated. Returning the client to the justice system for such a minor infraction is inappropriate if he/she is otherwise participating in treatment and free from drugs. Although the justice system must be advised of the infraction, the client may remain in TASC.

15 Minutes

7. Intervening With Problem Clients

Often the adjustment to treatment is not smooth, or after several months in treatment a client may test the limits. The TASC case manager has several intervention strategies available if a client's behavior signals less than success. Keep in mind, however, throughout each process the TASC case manager must continue to provide this information to the justice and treatment systems. Strong relationships and communication must be ongoing to ensure the court's goal of community safety and treatment's goal of rehabilitation. Two intervention strategies that can be used with problem clients are the case conference and alert/jeopardy status. Begin discussing this by displaying overhead 53 which presents a definition of the case conference.

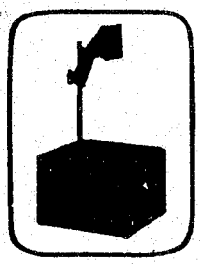


OVERHEAD 53

Case Conference

AN ACTIVITY THAT SERVES TO FACILITATE A CLIENT'S POSITIVE MOVEMENT IN TREATMENT OR MOVEMENT OUT OF THE SYSTEM.

As defined, a case conference is held to facilitate a client's positive movement in treatment or movement out of the system. Using the overhead entitled "Criteria for Determining Need of Case Conference," discuss possible events that might signal the need for TASC to call for a case conference.



OVERHEAD
54

CRITERIA
for determining need for case conference

- Client difficulty adhering to treatment requirements
- Treatment facility difficulty meeting client's needs
- Client's rehabilitation needs requiring referral to ancillary service
- Client's treatment needs requiring reevaluation or re-referral
- Client's nearing successful completion of treatment

Now discuss each of these criteria highlighting the following points. Be sure to ask for question or feedback from the participants.

- Determination of Case Conference Participants

  Participation in the case conference will be determined by the nature of the problem and/or issues to be discussed. The TASC case manager will select from among TASC, judicial, treatment, and medical personnel the most appropriate individuals to participate in the case conference with the client.

- Preparation for The Case Conference

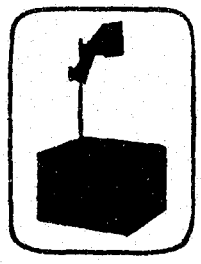
  The TASC case manager is responsible for coordinating the scheduling of the case conference with all individuals determined appropriate for participation.

  In preparation for the case conference, the TASC case manager is responsible for reviewing all facts relevant to the nature of the case conference and for briefing participants before the meeting.

- Case Conference Follow-Up

  The TASC case manager is responsible for documenting the case conference in the case management notes. Any decisions reached during the case conference will be subsequently evaluated for appropriateness and/or monitored for satisfactory follow-through.

Alert/jeopardy status is another case management technique to deal with problem clients. Alert/jeopardy is defined as:



OVERHEAD 55

ALERT/JEOPARDY STATUS

A MEANS OF WARNING THE TASC CLIENT HE/SHE HAS TAKEN A STEP TOWARD UNSUCCESSFUL TERMINATION.

Alert/Jeopardy Criteria need to be established and clearly explained to the client, treatment and justice personnel. Examples of Alert/Jeopardy Criteria are:

- An out-patient TASC client violating any one of the following criteria will be determined to be in an alert/jeopardy status with TASC:
  - failure to provide a urine drop for two consecutive weeks
  - failure to attend counseling sessions for two consecutive weeks
  - failure to attend a scheduled case conference or jeopardy meeting with TASC
  - continued use of drugs as evidenced by urinalysis
- A residential TASC client violating one of the following criteria will be determined to be in alert/jeopardy
  - repeated violation of facility rules and regulations
  - failure to return on time from an approved "pass"
  - failure to return within twenty-four hours is termination status
  - continued use of drugs as evidenced by urinalysis

The important point for emphasis here is that each TASC program should have some criteria established by which clients may be dealt with procedurally when they are not following through or progressing according to agreed upon expectations. No set procedure is the model, but some procedure should be in place.

30 Minutes

8. Case Conference Role Play

Trainer Note: Select four volunteers to play the role of treatment counselor, client, probation officer and case manager. The role descriptions are at the end of this model. Prior to this role play make copies of the roles. Assign each volunteer a role and ask them to take a few moments to prepare to play that role.

Provide this setting to participants: for the past hour or so we've been looking at the mechanics of alerting clients and criminal justice when there is the potential for failure in treatment or TASC. Let's bring this material to life with a case conference role play exercise. Volunteers have agreed to play the roles of a client in residential treatment, his/her treatment counselor, TASC case manager, and probation officer.

Here's the scenario:

- Client has been threatening to leave the residential facility where he/she has been mandated.
- Client has been disruptive on kitchen duty.
- Client refused to submit to urinalysis five days ago.

As a result of the situation described above, the TASC case manager issued an alert notice and requested a case conference to determine the course of further treatment.

This client has been in treatment for four months. He/she initially responded well, progressed appropriately, and submitted clean urinalyses.

Instruct the players to convene the case conference. Instruct them to:

- review the events leading up to the conference
- try to keep their comments within the confines of their biographical sketches
- reach consensus on a new treatment plan for the client

Allow 15-20 minutes for the exercise. Refer observers to the observation form on page 52 of the participant manual for recording their observations. Process group observations and allow players time to share their concerns and attitudes surfaced in the role play.

Conclude this section by reinforcing the following points:

- there is always alot more going on than meets the eye.
- there is value in direct communication.
- TASC functions again as the bridge that allows the client, treatment, and criminal justice to work in concert.

5 minutes

9. Summary

Review the essential components of case management. Be sure to emphasis that without effective monitoring and case management, there is little accountability to ensure that the TASC client will follow through with requirements or will receive the full continuum of services necessary for success. The credibility of TASC with the justice system rests heavily upon adequate case management procedures. Ask the participants for questions or issues that need clarification. Once this is completed, you may want to take a break.

BIOGRAPHICAL SKETCHES

Client - Received a letter from his girlfriend two weeks ago saying that she had decided she couldn't wait for him to complete treatment. She didn't trust him anyway, since she heard he was "making it" with another resident in the program.

He hadn't told his counselor about the letter, but had been docked by a night staff person for using the phone without permission. Two nights later he had gone "out the window" at night and went to see her. When he went to where she had lived he found someone else living there.

After that he looked up some buddies he knew and spent most of the night smoking pot and snorting coke. About 4 a.m. they took him back near the treatment center and he snuck back in.

Word was out on the floor that he'd gotten high, but no one took it to the group. He feels lost without his girlfriend and frustrated that he can't get high. His probation officer had told him that he'd see he went to prison if he left threats. He has said, "You can run, but you can't hide and after we catch up with you we'll send you where those real men upstate will like you just fine." He's scared and feels as if he has no good alternatives.

Counselor - You've just graduated from college with a BSW, you've been on the job two weeks. You always thought you wanted to help drug addicts, but now you're not so sure. These people are such manipulative, whiny, spoiled brats. They won't follow rules and are lazy. You've already begun applying for other jobs. You haven't had a chance to talk with the client since he refused to drop a urine last week. You recommended to the Director that the client be terminated, but he said to wait for the outcome of the case conference. You've been avoiding the client because you don't like him. You're going to argue that he be terminated.

Probation Officer - You've worked in probation for five years. You don't have a very high opinion of the treatment program the client is in. You think there's dope in the program and the drug treatment is ineffective. You generally try to use the big stick with clients to get them to comply. However, you know that it's unlikely the judge would send this guy to prison if he gets kicked out of treatment. You want to do your best to keep him in the treatment program and out of your office and hair.

TASC Case Manager - You've observed this client for almost four months. Your records indicate that he had been highly motivated, optimistic, and plugging into treatment very well until the past two weeks. You are unimpressed by the client's new counselor. It seems as if the counselor is both unprepared and unwilling to work with drug abusers. Your sense that perhaps you can get the client back on track if you can get a new counselor assigned the case.

MODULE IX: URINALYSIS TESTING

TOTAL TIME: 1 hour 5 minutes

PURPOSE

This session is designed to demonstrate the value of urinalysis in the identification, diagnosis, monitoring and management of TASC clients.
Also, this session is designed to inform participants of the need for detailed policies and procedures regarding urinalysis.

OBJECTIVES

Upon completion of this module, participants will be able to:

- List three TASC critical elements where urinalysis is used
- List two types of technology available for testing urine
- Differentiate between screening and confirmation tests
- List four activities involved in the chain of custody process
- Describe one method for implementing random urinalysis
- List at least three special problems in urine monitoring and methods for addressing those problems

MATERIALS

Overhead Projector
Overheads
Flipchart Stand/Paper
Handout Materials
Markers
Urine Bottles
Client File (simulated)

MODULE IX: URINALYSIS TESTING

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes **1. Introduction**

It is not necessary to be a urinalysis expert to train this module. The emphasis is on developing an awareness of the importance of urinalysis to TASC credibility. In addition, urinalysis is the most reliable method of determining clients' drug use if it is conducted in such a way that results cannot be faked or disputed.

Review each of the objectives of this module. Emphasize that the goal is not to make urinalysis experts out of all TASC staff, however, all staff must clearly understand basic urinalysis concepts.

10 Minutes **2. Linking Urinalysis to TASC Critical Elements**

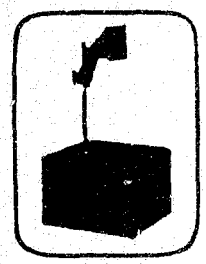
Inform the group that at least three of the TASC critical elements can use urinalysis as an essential component of the service. Ask the group to identify these critical elements and explain how urinalysis benefits the TASC service provided.

Answers should include:

- Identification - urinalysis can be used to verify current drug use reported and/or as a means of determining eligibility (Element 7).
- Assessment - urinalysis can again be used to verify use reported (Element 8).
- Case Management - urinalysis can be used to verify client's compliance with the case management plan (Element 10).

Overhead 56, a 1986 study by Wish et al, shows the comparison of reported drug use by arrestees to actual results of drug use indicated through urinalysis testing. This study complements other National Institute of Justice studies completed and in progress that continue to indicate the credibility and reliability of urinalysis technology.

Wish, Eric, Brady, E., Cuadrado, M. Urine Testing of Arrestees: Findings from Manhattan. New York City: National Institute of Justice, 1986.



OVERHEAD
56

NEW YORK CITY JAIL
Urinalysis Screening Results

	Reported Use by Inmate (N=4847)	Positive Urinalysis (N=4847)
Cocaine	20%	42%
Opiates	14%	21%
Methadone	6%	8%
PCP	3%	12%

Ask the group what this chart indicates. Is it possible that our clients might not tell us the whole truth about their drug use?

Close with the following comments. The nature of the drug abuser is to deny and minimize as a means to continue use of the drug while appearing to comply with treatment and criminal justice. Thus, urinalysis must be employed with TASC clients to assure that they remain drug free and succeed in treatment.

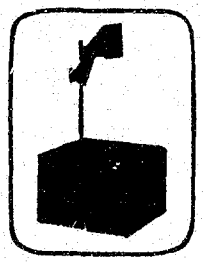
15 minutes

3. Urinalysis: Technologies and Considerations

Urinalysis technology is advancing so rapidly that the information on urinalysis being presented may soon be outdated. Thus, this training will focus on informing participants of general urinalysis concepts. Urinalysis technology can be divided into two broad categories:

- screening tests - which provide a highly probable assessment of drug byproducts in urine
- confirmation tests - which conclusively determine the presence of specific substances in urine.

Refer participants to page 54 in their manuals. This is a list of technologies for both screening and confirmation tests. Now describe these tests using overheads 57 & 58



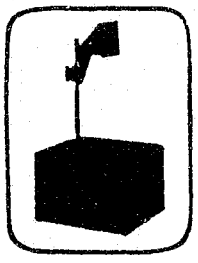
OVERHEAD
57

screening tests

Definition: Technologies that measure the by-products of substances as a means of making an initial determination of use or abstinence.

Technologies Employed:

- Radioimmunoassay (RIA)
- Enzyme Immunoassay (EMIT)
- Therapeutic Drug Monitoring System (TDX)
- Thin Layer Chromatography (TLC)



OVERHEAD
58

confirmation tests

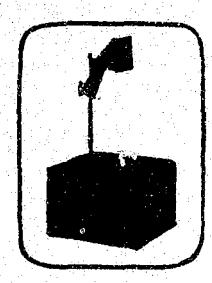
Definition: Technologies that actually search for the chemical composition of the drugs being tested and confirm their presence with greater technological accuracy.

Technologies Employed:

- Gas Chromatography (GC)
- Gas Chromatography/Mass Spectrometry (GC/MS)
- High Pressure Liquid Chromatography (HPLC)

Inform participants that both screening and confirmation tests have a role to play in TASC programs.

Ask participants to review uses of the results of screening tests found on page 55 in their manuals. Display Overhead 59. Solicit and record additional responses from the participants on a flipchart or overhead.



OVERHEAD
59

uses of screening tests

IDENTIFICATION OF THE DRUG OFFENDER
CLIENT CONFRONTATION
DETERMINING JEOPARDY STATUS
CONFIRMATION THAT CLIENT IS DRUG FREE

uses of confirmation tests

CONFIRM, REJECT SCREENING TEST RESULTS
SUBMISSION AS EVIDENCE IN COURT

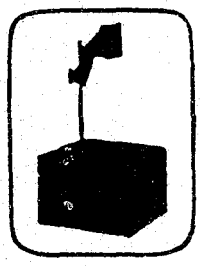
Next ask participants to review uses of the results of confirmation tests. Again ask the group if there are other uses for confirmation tests. Summarize by reviewing the value screening tests and considerations for using confirmation tests.

15 minutes

4. Chain of Custody

In this segment, participants will review the importance of the concept of a chain of custody and why it is necessary to develop a protocol for a chain of custody. Define chain of custody as policies, procedures and protocol for the security of justice system evidence.

Focus on why a chain of custody is necessary. A chain of custody will not ensure credibility with the justice system unless the procedures established for the chain are comprehensive and followed. As urinalysis technology becomes a more viable means of identifying drug involved individuals in and outside the justice system, courts will be looking harder and harder at the chain of custody issue. Display overhead 60 which highlights the steps in the chain of custody. This information is found on page 56 of the participant manual.



OVERHEAD
60

CHAIN OF CUSTODY

COLLECTION

CLIENT SPECIMEN IDENTIFICATION

TESTING

REPORTING

Discuss each of these broad categories of the Chain of Custody explaining what they encompass and how they may vary depending on the use of in house technology vs. using an outside laboratory.

- Collection - includes an observer during specimen collection. The amount of urine submitted needs to be considered. Discuss why the client needs to be observed and what are the potential ramifications if the client is not observed?

- Specimen Identification - ensures that the client specimen is marked, sealed and remains the same clients specimen. Should include discussion of security of collection container, sealing, labeling, carrying to testing site, etc.

- Testing - Issues to consider are on and off premise testing transfer responsibility, time between submission and testing, testing vs. confirmation.

- Reporting of Results - turnaround time, what is reported, to whom it is reported, how results are to be used and what if confirmation is necessary.

After presenting the chain of custody concept, the training team will now visually display the essentials of the chain of custody procedure following the role play scenario outlined below. One trainer should role play the TASC staff, the other trainer simulates the TASC client, the lab technician, the probation officer and the judge:

Step 1

TASC Staff: back turned to trainees as he/she observes submission of urine

Client: simulates provision of specimen

TASC Staff: takes container, views it to ensure there is enough urine to be tested and/or retested and/or confirmed, seals container, labels it, and carries it to the lab for sign-off to lab personnel

Step 2

Lab Person: takes container, documents information on label, tests specimen, documents findings, calls results to to TASC. Positive results.

TASC Staff: receives results, documents results in the client file, notifies treatment and justice personnel and client. This positive urine result places client in a termination status.

Step 3

Probation Officer: calls TASC personnel with court date for violation

Step 4

TASC Staff: provision of court testimony, which relates to Chain of Custody.

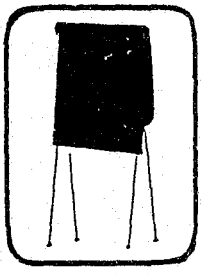
Judge: asks several questions about chain of custody and how TASC is assured urine in question belonged to said client

In summarizing the Chain of Custody, process, ask the participants to brainstorm points where Chain of Custody can break down and how to avoid these breakdowns to ensure the credibility of the urinalysis process.

Be sure to emphasis that the purpose of maintaining a chain of custody is to guarantee that the urine results tested and reported are accurate and truly those of the client who gave the urine.

10 minutes

5. Problems Associated with Urine Collection



FLIPCHART

Ask participants what problems are most likely to occur when clients come in for urinalysis. Create a list on a flip chart. Responses should include:

- tampering with specimen
- attempted bribery
- inability to void
- infection control

Solicit from the group suggestions on how to effectively prevent or deal with these problems. Responses should include:

Tampering - Have policy that permits calling in clients for testing at any time. Make sure that participants know common tampering scams (adding salt, bleach, vinegar, Drano to specimen), diluting specimen with water, and bringing in samples hidden in pockets, body cavities, etc. Stress the absolute need for either visual monitoring of specimen or lab setup that ensures against specimen being brought in or tampered with while being provided.

Bribery - Advise client he/she is committing an illegal act by offering a bribe. Immediately report incident to supervisor.

Inability to Void - Don't succumb to requests to provide privacy. Give reasonable time, then remove client from lab, advise that specimen must be provided that day, and have consequence procedure in place for client's failure to provide specimen.

Infection Control - Refer to Centers for Disease Control guidelines for health care workers who handle body fluids which reference rubber gloves, clean-up procedures, etc.

10 minutes **6. A System of Random Urinalysis**

Trainer should review the Birmingham, Alabama, TASC program procedures for random urinalysis which is included below and which is also included on page 57 in the participant's manual. Have participants turn to this page and review it as the trainer covers the material.

Emphasize that this is one method of scheduling random urinalysis that has proven viable. It is, however, the responsibility of each program to develop procedures that work for it. Also note that this method allows the program to maintain a schedule while maximizing the therapeutic potential of urinalysis.

ALABAMA TASC

ALABAMA - Instructions for Color Coded, Random Urinalysis

Listed below are the instructions you will follow in TASC's Color Code Urinalysis System. Through cooperating with this program, you can help yourself by proving to the Criminal Justice System that you are drug-free.

1) You will be assigned a color by your TASC Counselor.

2) You will call the following number at the Federal Parole Office <u>every day including Saturday and Sunday</u> (you may call any time day or night).

3) A recording will give you the color of the day. If your color comes up, you will report to the TASC office the <u>next day</u> to leave a urine specimen. (Example: You call on Monday. Your color is given on the recording. Then you will come in on Tuesday to leave a urine.

   NOTE: Be sure to call the number every day to get the correct color for the next day.

4) Urine specimens are collected by a nurse from 6:00 a.m. to 11:00 a.m. and 1:00 p.m. to 6:00 p.m. on weekdays, and Saturday and Sunday from 9:00 a.m. to 12:00 noon. We observe and verify collections to support our testimony in court.

5) When you come in for urinalysis, you will be required to pay for the cost of processing the sample.

The Color Code System is designed to help you by:

- Giving you a daily reminder of your decision to stay away from drugs.
- Making it necessary to give up your habit entirely since this system is random, and you will never know when your color is coming up.
- Helping your TASC counselor feel confident in providing a positive, good report of your progress to the courts.

IT'S ALL UP TO YOU.

5 Minutes

7. Summary

Conclude this module by reviewing the material already covered, highlighting the steps for maintaining a chain of custody. Emphasize once again the importance of urinalysis as a tool in the TASC operation. Summarize again the benefit of urinalysis to the TASC critical elements of:

- Identification
- Assessment
- Monitoring

This is an ideal time to take a break.

MODULE X:

RECORDKEEPING AND DATA COLLECTION

TOTAL TIME: 1 hour 25 minutes

PURPOSE

This module is designed to introduce participants to the need for clear and complete recordkeeping, the benefits to their individual performance, and to TASC credibility.

OBJECTIVES

By the end of the module, participants will be able to:

- List two different kinds of information needed from a client record by a TASC case manager.
- Identify three negative situations that could result from poor or incomplete recordkeeping.

MATERIALS/DOCUMENTS NEEDED

Flipchart Stand/Paper
Overhead Projector
Overheads
Markers
Masking Tape
Sample Client File

MODULE X:
RECORDKEEPING AND DATA COLLECTION

TIME/MEDIA & MATERIALS:

outline of training activities

5 Minutes

1. Introduction

In this session, you will be helping participants develop an appreciation for the importance of data collection and record-keeping and their contribution to client processing, staff decisions, and program success.

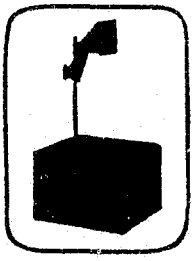
Paperwork can seem unrewarding at best, and odious at worst. Nevertheless, accurate and up-to-date paperwork is absolutely essential if a TASC program is to run effectively. It is critical to professional functioning and integrity in all of the TASC roles from line staff through management. Without it the staff can face both personal embarrassment and professional liability. Without good records the program can quickly lose credibility.

10 Minutes

2. Planned Record Keeping Strategies

The collection of a client record and the compilation of program data can be easy or difficult depending upon whether participants proceed with a good plan that focuses on needed information.

Using overhead 61 you should introduce to the group the key elements of the record keeping plan to the group. Provide a few brief examples of each element and then proceed to the next section.



OVERHEAD 61

RECORDKEEPING PLAN SHOULD IDENTIFY

STANDARD TERMS TO BE USED;

NEEDED DATA;

STREAMLINED PROCEDURES FOR COLLECTING THE DATA TO AVOID DUPLICATION AND TO PERMIT THE RECORD TO BUILD UPON ITSELF;

A LOGICAL STRUCTURE THAT MAKES THE REVIEW OF THE RECORD EASY AND THE CLIENT STORY CLEAR AND UNDERSTANDABLE.

Once you have identified the above elements you should proceed with a discussion on each of these areas, covering the following points. Add items identified by the group.

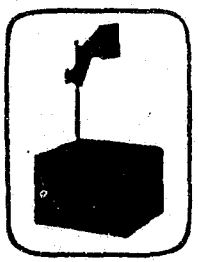
- Standard terms to be used include:
  - Intake
  - Summary
  - Staffing
  - Discharge notes

- Needed data - what data should be recorded
  - Charges
  - Screening Date
  - Court liaison notes
  - Intake Assessment
  - Referral

- Streamline procedures - establish streamlined procedures for collecting the data. Make sure duplication of effort is prevented. Make sure forms gather new information and not repeat already collected data. The record should build upon itself. After reviewing the client file the case manager should have a comprehensive picture of the client.

- A logical structure that makes the review of the record easy, clear, and understandable. This includes:
  - Functional file folders
  - Standardized filing
  - Intake
  - Progress notes
  - Set format for where specific information should be placed in the file

Overhead 62 outlines the elements of a good case note and what to avoid in writing case notes. Refer participants to page 60 in their manuals. Discuss each of these points.



OVERHEAD 62

▪ ELEMENTS OF A GOOD CASE NOTE

- Objective information
- Clarity
- Conciseness
- Summarization of the activity

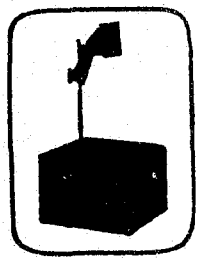
▪ WHAT TO AVOID IN CASE NOTES

- Subjectivity
- Personal bias
- Hearsay/unfounded information
- Failure to indicate date, time, and location of interaction with client and method of interaction (in person, by telephone, or by correspondence)

15 Minutes

3. File Management and Reporting

Before you begin a discussion on file management, you may want to ask the group who is routinely charged with entry of data into the client case file? Using overhead 63, discuss each of the essential elements that should be included in a file. An individual file must be maintained on each client. This information is found on page 61 in participant manual. This file must include:



OVERHEAD 63

File to Include:

- a copy of original assessment;
- a copy of original recommended plan sent to treatment
- a copy of the justice mandate;
- signed consents and client agreements;
- case management notes that relay the client's story to include
  - all face-to-face and telephone conversations with the client (date);
  - all face-to-face and telephone conversations with counselor about the client (date, counselor's name);
  - all urinalysis submissions (date and results);
  - any alert hearings, court appearances, case conferences, (date, who attended, purpose, and result);
  - all referral efforts or contacts made for ancillary services (date, names of contacts, services);
  - all other conversations about client, (i.e., family members) within the confines of confidentiality laws (date, purpose);
  - any efforts made to contact client or justice or treatment personnel;
  - any verification regarding client employment, hospitalization, school, etc. (date, contact).

Embellish each of these points emphasizing how the client file is the clients story. If anything is left out its like reading a book with a chapter missing.

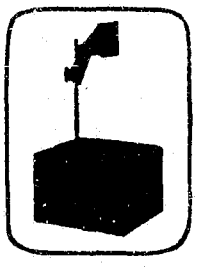
20 Minutes

4. Progress Notes and Data Recording

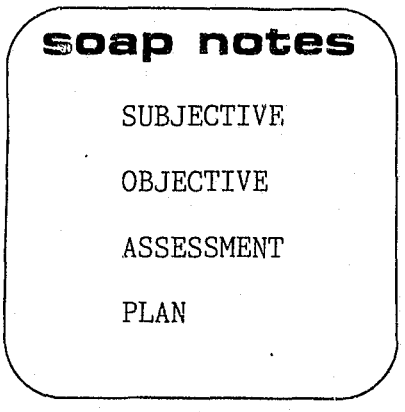
It is absolutely essential to have complete and comprehensive data collected on all TASC clients. Because TASC is the bridge between the treatment and criminal justice systems, data plays a significant role. TASC serves as the conduit to transfer information about the client's progress between these two systems. As a result, TASC must keep accurate data on treatment progress, urinalysis status, and justice system status. Without adequate, accurate data, TASC will be unable to speak authoritatively about the client's progress. A scenario like this will create a credibility problem for the TASC program.

Case management notes are essential to the TASC file. This documentation begins with the reason the client is accepted into TASC. From that point all contact with the client or with either the treatment and criminal justice systems about the client must be recorded succinctly and objectively.

There are several methods for recording case notes. It doesn't matter what method is used as long as it assures accurate and complete data. One method advocated is the SOAP method. The acronym stands for Subjective, Objective, Assessment, Plan.



OVERHEAD
64



Cover the following points on this method

- Subjective - in this first section is recorded information and reports that come to the TASC case manager from other sources such as the patient himself, family members, probation officer or the treatment counselor

- Objective - in this section is recorded data and observation the case manager makes directly, i.e. the client was disheveled and slurred his speech

- Assessment - in this section is recorded a brief word or phrase which succinctly summarizes and distills all available information

- Plan - in this section are noted the case managers plans which typically may include discussions of client with the treatment counselor, reporting problems to the probation officer, need for a case conference, referral to ancillary services or making a recommendation for termination.

Again, the emphasis is on a clear, objective, and comprehensive recording of the client's behavior and progress. Whatever method is used to achieve this goal is acceptable.

Now we want to practice writing case notes. Each participant is asked to read the client-TASC case manager scenario presented on pages 62-63 of the participant's manual. Have participants read the interaction that took place. Now ask them to record the interaction in the space provided for a progress note.

The case scenario is included at the end of this module for the trainers use.

Once the participants have recorded their notes, have them break into groups of three and discuss what they wrote. Ask them to see if common information appears in their notes. Now facilitate a discussion on common threads among all the groups. Summarize by highlighting the essential points that needed to be included in the progress note.

30 Minutes **5. Exercise: Case Record Scenario**

The purpose of this exercise is to drive home the point that good recordkeeping can protect the case manager from having to answer questions for which he/she doesn't have the data.

Ask for two volunteers. Give one Scenario A and the other Scenario B. Both scenarios are included at the end of this module. Inform them that their client is in court on a probation revocation hearing. The judge has asked the TASC case manager to report on the client. Bring the volunteers into the room one at a time. Simulate a court scene. One of the trainers is to serve as the judge. The judge is to ask the case manager a series of questions and to document whether the client violated his/her probation.

Invite all the other participants to review the scenarios on pages 64-66 in the participant manual. After the role plays are completed, process the experience. Ask each volunteer if it was difficult to answer the judge's questions. Ask the judge which volunteer provided the more useful information. Finally, ask the other trainees to reflect on what they saw.

Summarize this section by emphasizing again the need to collect strong, objective data. Point out that this type of recording guarantees the case manager the information necessary to substantiate client progress in TASC.

5 Minutes

6. Summary

Summarize the modules by making the points that verbal information may be misunderstood. Written information provides a sequence of actions for one to recall. Writing should be: efficient, routine, and timely. Benefits to staff and the program of good record keeping are:

- good information/records help staff do their job better
- good records help the program be more effective
- good records provide credibility with the courts and treatment.

Finish by pointing out that a recordkeeping plan should identify:

- standard terms to be used
- what data are needed:
- streamlined procedures for collecting the data so there is little duplication and the record builds on itself
- a logical structure that makes the review of the record easy and the client story clear and understandable.

This is an ideal time for a break.

EXERCISE: RECORDING PROGRESS NOTES

32-year-old Larry has been involved in the TASC program for three weeks. Since his enrollment in the program he states the following to his counselor:

Larry:
I've been in the program for three weeks now and already you are on my back about how many times I have to piss in the damn bottle.

Counselor:
Well, Larry, as I outlined on your treatment plan, you will be required to submit to random urinalysis on a weekly basis.

Larry:
I still don't care what the tests say. I haven't had any damn toot since I've been arrested.

Counselor:
Larry, the tests conducted indicate a positive for cocaine. What do you have to say about that?

Larry:
Nuthin.

Counselor:
Larry, I told you that participation in group is also a required part of your treatment program.

Larry:
Yeah, tell that to my damn foreman. I lost my job and then I lost my ride.

Counselor:
Larry, you lost your job this week, yet you missed group the first two weeks you were in the program, and as I recall you had no trouble riding over for urine testing in your car during the same period of time.

Larry:
Yeah, I forgot that I had group on the same day you wanted some piss.

Counselor:
Larry, can you also account for not checking in with the re-employment agency?

Larry:
I told you - no ride.

Based on the above information, you are to write a progress note in Larry's record. You may be considering a formal warning in the very near future so documentation is essential. You have five minutes to complete this task.

SCENARIO A

Background and Initial Plan

- 33-year-old white male
- entered treatment approximately July for polydrug abuse
- Treatment Assigned:
  - Outpatient sessions
  - Random Urinalysis
  - Group activities

Notes

- July - October - Client attended outpatient and group as assigned
- Stopped attending. TASC case manager tried to contact. No contact made
- Client returned to treatment on 11/15, first alert jeopardy
- 4 Urine Specimens positive for cocaine
- 2/4 Second alert jeopardy
- 2/8 status call
- client attends group
- April 21, threatened another client in group
- April 22, Third alert jeopardy - termination

SCENARIO B

Background and Initial Plan

- 33-year-old white male

- Date of treatment initiation: 7/20
  Drug of abuse: cocaine

- Treatment Schedule
  - Outpatient 2 sessions per week
  - 1 random urine submission per week
  - 1 group per week

- July compliant with outpatient
  Attended 7/21, 7/23, 7/26, 7/29
  Urinalysis 7/22 - negative
  7/28 - negative
  Group 7/25 moderate participation
  7/30 good participation

- Aug. outpatient sessions attended
  Aug. 2 Aug. 5 Aug. 9 Aug. 12
  Aug. 16 Aug. 19 Aug. 23 Aug. 26

- Aug. urinalysis:
  Aug. 4 negative
  Aug. 11 negative
  Aug. 18 negative
  Aug. 25 negative

- Group attendance
  Aug. 3 moderate participation
  Aug. 10 good participation
  Aug. 17 good participation
  Aug. 24 good participation

- Sept. outpatient sessions
  Sept. 2 Sept. 5 Sept. 9 Sept. 12
  Sept. 16 Sept. 19 Sept. 23

- Sept. urinalysis:
  Sept. 7 negative
  Sept. 12 negative
  Sept. 20 negative
  Sept. 28 negative

- Oct. outpatient sessions attended
  Oct. 2 Oct. 5 Oct. 9 Oct. 12
  Oct. 16 Oct. 19 Oct. 23 Oct. 26

- Aug. urinalysis:
  Oct. 4 negative
  Oct. 11 negative
  Oct. 18 negative
  Oct. 25 negative

- Group attendance
  Oct. 3 moderate participation
  Oct. 10 good participation
  Oct. 17 good participation
  Oct. 24 good participation

- November 10 - client has not attended any group activity since October 24.Attempts to contact client on October 25, 28, 29 No contact made by this writer.

- November 2 - Probation advised of client's current status. First alert/jeopardy scheduled 11/15.

- Positive urinalysis cocaine - per testing on 11/20, 12/7, 1/18 and 1/30

- Second alert/jeopardy scheduled 2/4

  2/6 - Status call scheduled for 2/8
  2/8 - Status call, probation officer Smith in attendance
  3/5 - Only one group attendance since 10/24
  3/7 - Attempted to reach client 2 x this week - No contact made
  3/2 - Positive urinalysis - cocaine
  4/3 - Case disposition with probation officer

  4/22- Third alert/jeopardy - termination

MODULE XI: CONFIDENTIALITY

TOTAL TIME: 3 hours

This module is designed to introduce participants to the concept of confidentiality of alcohol and drug abuse patient records and how the confidentiality regulations are applied when working with TASC clients.

OBJECTIVES

By the end of the session participants will be able to:

- Describe which records are covered by the confidentiality regulations.
- List the nine elements that must be included in a general release.
- Describe the differences between a general consent for release and a criminal justice release.
- Describe the conditions where minors must sign their own releases.
- Describe the seven situations where information may be released without a client's consent.
- Describe the differences between a subpoena and a court order as they apply to the confidentiality regulations.
- Describe how to respond to a subpoena.

MATERIALS/DOCUMENTS NEEDED

Overhead Projector
Overheads
Flipchart Stand/Paper

Federal Confidentiality Regulations, June 9, 1987, Federal Register

MODULE XI: CONFIDENTIALITY

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes

1. Module Overview

Briefly present an overview of the module content as well as the rationale for considering confidentiality.

Emphasize that the confidentiality of the drug and alcohol abusers' records have more set procedures and prohibitions than do the records of mental health clients. Indicate that the specific procedures and rules governing the confidentiality of client records is contained in the Federal regulation Confidentiality of Alcohol and Drug Abuse Patient Records from Title 42 of the Code of Federal Regulations (CFR), Part 2. This regulation, which was originally implemented in 1975, was revised in 1987. Specific differences between the original and revised regulations will be discussed.

Trainer Note: To most effectively deliver this module, you need the answers to two questions from the state where the course will be delivered. They are:

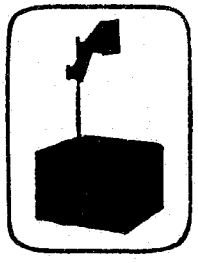
- Does the state have alcohol and drug patient confidentiality regulations that are more restrictive than the Federal regulations?
- Does a minor need his/her parents' permission in order to receive alcohol or drug treatment?

Both of these issues will be addressed in this training. Having the answers will help you facilitate discussion in these areas.

15 Minutes

2. The Regulations - Background

Overhead 65 provides the key points related in the background and rationale for the regulations:



OVERHEAD 65

BACKGROUND OF REGULATIONS

EARLY 70'S - BASIS IN LAW

1975 - REGULATIONS APPROVED AND ADOPTED

DESIGNED TO ENHANCE TREATMENT

CHANGES REVIEWED: 1980, 1983

REVISION: AUGUST 10, 1987

RELATION TO STATE LAWS

Provide participants with a brief background about the history of the regulations and their basis in law. Report that the authority for all governmental regulations ultimately derives from law. Federal regulations cannot be imposed unless Federal law, the law of the land, permits or mandates that these be written.

In the early 1970's the U.S. Congress passed several laws pertaining to alcoholism and drug abuse. Although they were primarily aimed at funding substance abuse services, they also authorized the U.S. Department of Health, Education and Welfare (DHEW), now the U.S. Department of Health and Human Services, to develop special regulations pertaining to the confidentiality of client records.

In mid-1975, after comments were received from the public, DHEW adopted what is known as the Federal Confidentiality Regulations. These regulations covered nearly 20 pages of fine print in the Federal Register.

The regulations, as well as the laws upon which they were based, are designed to protect the privacy rights of individuals who obtain treatment for substance abuse problems, and enhance the quality and attractiveness of alcohol and drug abuse treatment programs. It was believed by lawmakers that confidentiality would help prevent discrimination and assure more involvement in treatment of the drug or alcohol involved individual.

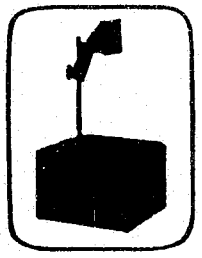
After the regulations were implemented in 1975, it became apparent that fine tuning was needed. Changes were proposed in 1980 and 1983, and public comment was solicited. In mid 1987, the long discussed revised regulations were adopted. They were published in the June 9, 1987, Federal Register (Vol. 52, No. 110) and became effective August 10, 1987. The regulations are still detailed in 42 CFR Part 2. "U.S.C." stands for "United States Code." This is the document that contains all Federal laws. "CFR" stands for "Code of Federal Regulations" and is the document that contains all Federal regulations.

The Federal Confidentiality Regulations should work in harmony with existing state and Federal laws and regulations. They should not be used as a vehicle for individuals to hide behind while breaking or not complying with other laws. In fact, the revised regulations make it much easier for programs to report suspected cases of child abuse and to notify authorities when there is a threat of harm to anyone by a client.

The regulations are not intended to preempt state laws. States may make the regulations **MORE** restrictive. However, no state law may authorize any disclosure that is prohibited by the regulations.

The regulations should be viewed as minimum standards and procedures to be followed by individuals and programs. The emphasis in the rules is on the protection of the client from unauthorized release of confidential information. Display

Overheads 66 and 67 which outline the five subparts of the regulations and the topics in each subpart that will be discussed in this training.



OVERHEAD 66

Federal Confidentiality Regulations 42CFR Part 2

subpart A INTRODUCTION

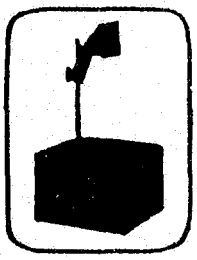
- Statutory authority for confidentiality of alcohol and drug abuse patient records
- Purpose and effect
- Criminal penalty for violation
- Reports of violations

subpart B GENERAL PROVISIONS

- Definitions
- Minor patients
- Incompetent and deceased patients
- Security precautions
- Undercover agents and informants
- Relationship to state laws
- Notice to patients of Federal confidentiality
- Patient access

subpart C DISCLOSURE WITH PATIENT'S CONSENT

- Form of written consent
- Prohibition on redisclosure
- Disclosures permitted with written consent
- Disclosures to elements of the criminal justice system



OVERHEAD
67

subpart D DISCLOSURES WITHOUT PATIENT'S CONSENT

- Medical emergencies
- Research activities
- Audit and evaluation activities

subpart E COURT ORDERS AUTHORIZING DISCLOSURE AND USE

- Legal effect of order
- Procedures and criteria for orders authorizing noncriminal purposes
- Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients
- Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or person holding the records
- Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program

Indicate that there is not enough time to go over all the regulations. Special attention in this training will focus on what TASC staff need to know. Then briefly review the contents of this training by mentioning the following points:

- **subpart A** INTRODUCTION

  The sections in Subpart A describe the legal basis for the confidentiality regulations, their purposes, how violations should be reported, and the criminal penalties for violations. The Federal statutes discussing confidentiality are quoted in Section 2.2

- **subpart B** GENERAL PROVISIONS

  These selections provide detailed definitions for all key regulation terms and explanations about which programs and records the regulations apply to (including certain exceptions), a clear explanation of the restrictions imposed by the rules, the applicability of the regulations to minors, issues surrounding incompetent individuals and the records of deceased clients, the security of records, the limitations on undercover agents and informants in treatment programs, a number of special regulations applicable primarily to methadone programs, required notices to clients when their records are subject to these regulations, and a clarification concerning the clients' access to their own records.

- **subpart C** DISCLOSURES WITH PATIENT'S CONSENT

  This Subpart describes the required elements for the consent to a disclosure of confidential information, limitations on the re-release (redisclosure) of protected information, special regulations concerning methadone programs, and clearly defined regulations concerning criminal justice system-related releases.

- **subpart D** DISCLOSURES WITHOUT PATIENT'S CONSENT

  These sections describe those circumstances where confidential information may be released without a patient's consent.

- **subpart E** COURT ORDERS AUTHORIZING DISCLOSURE AND USE

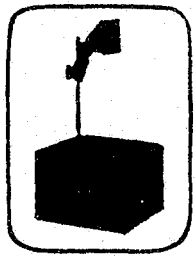
  This section explains the procedures for obtaining court orders for the release of confidential information, as well as the limitations of such orders. Different procedures and criteria apply with respect to disclosures in criminal and non criminal instances.

40 Minutes

3. Overview of the General Rules and Concepts

Point out that the material to be presented next will not always follow the order of the material in the regulations. During this time, introduce the participants to the general rules and concepts of the confidentiality regulations. Your goal is to have participants finish this section with a good, fundamental understanding of who and what are covered by the regulations.

Cover the following concepts by first presenting the concept and then soliciting questions and discussion as you go along. The following overhead may help facilitate in making these points.



OVERHEAD 68

General Rules and Concepts

A. Applicability

- all information on alcohol/drug patient by federally assisted program

B. General Restrictions

- in most cases, no release without consent
- applies to present and former employees

OVERHEAD 68
continued on next page

OVERHEAD 68 continued

C. What is Covered

- all records and communications of individual who has applied or been diagnosed, treated, or referred to treatment
- any information that identifies patient

D. Who is a Patient

- anyone who has applied for or been given diagnosis, treatment or referral

E. What is a Program

- individual or agency that says it does alcohol or drug diagnosis, treatment, or referral
- in general hospital, the alcohol or drug unit

Further explain those five points through presentation of the following material.

- APPLICABILITY

  The Federal confidentiality regulations are applicable to all information about alcohol and drug patients obtained by a program that is federally assisted in any manner.

- GENERAL RESTRICTIONS

  In most circumstances, no releases may be made without the written consent of the patient. Disclosures are not permitted in any civil, legal, administrative or legislative proceeding conducted by any Federal, state, or local governmental authority. This restriction is unconditional, and applies whether or not the person seeking the information is a law enforcement officer or other official, has obtained a subpoena, already has the information, or asserts any other justification not permitted by the regulations. These regulations apply equally to present and former program personnel.

- WHAT INFORMATION IS COVERED?

  All records and communications, whether written or not, about any individual who has applied for or been diagnosed, treated, or referred for treatment, are covered by the regulations. Information covered includes name, address, photograph, fingerprints, or other similar data that may be used to identify an individual. It does not include any patient number assigned by the program, as long as that number is not be used to identify a patient.

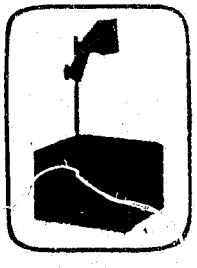
- WHO IS A PATIENT?

  A patient is any individual (whether referred to as a patient, client, or some other term) who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol and drug abuser in order to determine that individual's eligibility to participate in a program.

- WHAT IS A PROGRAM?

  A program is an individual, corporation, partnership, governmental agency, or other legal entity that holds itself out as providing, and provides, alcohol and drug abuse diagnosis, treatment, and referral for treatment. If the program in a general medical care facility, there must be an identified alcohol or drug abuse unit.

Continue the process by displaying overhead 69.



OVERHEAD 69

F. What is a Federally Assisted Program?

- is conducted or licensed by government
- receives Federal funds
- has not-for-profit or tax-exempt status

G. Unconditional Compliance

H. Acknowledging Presence of Patients

- may not acknowledge
- no drug or alcohol tag
- no restriction if person never a patient

I. Security of Records

- locked room or cabinet
- written procedures to control access

J. Patient Access

K. Written Notice to Patients

Once again embellish the points presented by covering the following material.

- WHAT IS A FEDERALLY ASSISTED PROGRAM?

  A federally assisted program is any alcohol or drug program:

  - conducted in whole or part, whether directly or through contract, by any branch of the U.S. government, with the exception of the Veterans Administration and the Armed Forces; or

  - is being carried out under license, certificate, registration, or other authorization by any branch of the Federal government.

  In general, any program that accepts Federal funds either directly or indirectly is covered by the regulation, including programs accepting Medicare, methadone treatment programs, state or local governments receiving revenue sharing (whether or not the revenue sharing funds support substance abuse services), tax-exempt non-profits, programs that can accept tax-exempt contributions, and the like. The Veterans Administration is exempt, and special conditions are placed on the Armed Forces.

  If a patient's alcohol or drug abuse diagnosis treatment is not provided by a program that is federally conducted, supported, or regulated as noted above, then the records of the individual are NOT covered by the regulations. Under the new regulations, all records are covered if the program benefits from Federal support.

- UNCONDITIONAL COMPLIANCE

  The regulations restrict the disclosure of confidential information regardless of whether the holder of the information believes the person seeking it already has it, has other means of obtaining it, is a law enforcement officer or other official, has obtained a subpoena, or asserts any other justification for a disclosure not permitted by the regulations.

- ACKNOWLEDGING THE PRESENCE OF PATIENTS

  The presence of an identified patient in any program or program component may be made only if the patient's written consent is first obtained, or if there is an authorizing court order. The following conditions apply:

  - If the facility is not publicly identified as only an alcohol or drug abuse treatment or referral facility, the presence of a patient may be acknowledged providing that such acknowledgement does not reveal that the patient is an alcohol or drug abuser.

- Any answer to a request for a disclosure of patient records, including the presence of the patient, is not permissible, and must be made in such a way that does not reveal whether the patient has been, or is being diagnosed or being treated for alcohol or drug abuse.

- The regulations do not restrict a disclosure that an identified individual is not and has never been a patient.

- STATE LAWS

If there is an applicable state law covering alcohol and drug abuse confidentiality, then the more restrictive law applies. Explain that because TASC is covered by the Federal confidentiality regulations, all TASC client information is thus protected. Even hospital-based programs are covered, since almost every hospital in the country directly or indirectly receives assistance from the Federal government.

Data collected by a jail screener are also covered, if collected to determine eligibility to participate in TASC, treatment, or to diagnose alcohol or drug abuse. If the questions are solely related to determining eligibility for pretrial release, the information is not covered.

- SECURITY OF RECORDS

Written records must be kept secure. The regulations specify they must be kept in a secure room, locked file cabinet, safe or other similar container when not in use. Further, each program is required to adopt written procedures regulating and controlling access to and use of written records.

- PATIENT ACCESS TO RECORDS

The Federal regulations do not prohibit a program from giving a patient access to his or her own records. A written release is not necessary.

- WRITTEN NOTICE TO PATIENTS

At the time of admission each program is required to tell patients that their records are confidential and protected by Federal law and regulation. Patients must be given a written summary of the law and regulations. The written summary must include:

- A statement that the confidentiality of alcohol and drug abuse patient records maintained by the program are protected by Federal law. Also a general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

- A statement that violation of the Federal law and regulations is a crime and that suspected violations may be reported to the appropriate authorities.

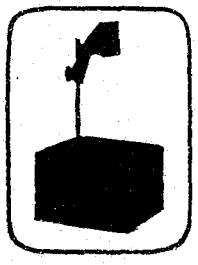
- A statement that information related to a patient's commission of a crime on the premises of the program or against program personnel is not protected.

- A statement that reports of suspected child abuse and neglect made under state law to appropriate state authorities are not protected.

- A citation to the Federal law and regulations.

A program may devise its own notice or may use a sample notice, which appears in the regulations. A copy of the summary appears on pages 21809 - 21810 of the regulations and would be similar to the notice on page 68 of the participant's manual.

The regulations include several issues regarding minors. These are summed up on overhead 70.



OVERHEAD 70

RULES AND MINORS

Who is a minor?

- anyone who has not obtained age of majority or 18.

Is parental consent necessary?

- if minor may receive treatment without parental consent, only minor signs release

- if treatment is contingent on parental consent, minor and parent or guardian sign release.

Applicant lacking capacity

- extreme youth or lacking capacity, program may make a disclosure (well-being of minor threatened)

Cover the issues about minors and confidentiality by making the following points:

- DEFINITION OF A MINOR

  A minor is anyone who has not attained the age of majority as determined by applicable state law, or under the age of 18 if state law is not applicable.

- PARENTAL CONSENT

  If state law permits a minor acting alone to apply for and obtain alcohol or drug treatment, then any written consent for the release of confidential information may be given only by the minor patient. In such instances, consent is required to disclose any patient identifying information even to parents. The regulations do not prohibit a program from requiring minors to give such consent, although in some states the law may be different.

  In states where parental consent is required for treatment, such consent for disclosure must be given by both the minor and his/her parent or guardian. In these states, if a minor applies for treatment, this information may be communicated to the parent.

- APPLICANT LACKING CAPACITY

  In those rare instances where because of extreme youth or the minor lacks the capacity to make a rational decision, and the situation poses a threat to the life or well being of the minor, the program may make a disclosure without written consent.

In summary, point out that in those states where minors may choose treatment without parental consent, they may also agree to release information without parental consent. In these states, releases should be obtained to discuss the confidential information with the minor's parent. If parental consent is needed for treatment, parental consent is needed for the release.

15 Minutes **4. Discloses With Patient Consent**

Begin this section by highlighting the three ways client information can be released:

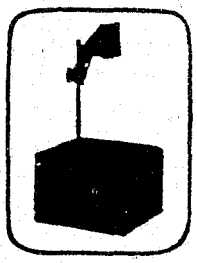
1) with patient's consent
2) without patient's consent
3) by court order

Indicate these will be discussed one at time beginning "with patient's consent."

Point out that recent changes have been made in the regulations. Thus, some of the material presented here will be different from the present disclosure practices of virtually all programs. Where there have been meaningful revisions in the regulations, those revisions will be noted.

- REQUIRED INFORMATION FOR GENERAL RELEASES

Unless otherwise specifically exempted by the regulations, written consent by the patient is required in order to release confidential information. The release form must contain certain mandated information, as noted below, and on page 69 of the participant manual.



OVERHEAD 71

release must contain

1) The specific name or general designation of the person permitted to make the disclosure.

2) The name or title of the individual, or name of the organization, to which the disclosure is to be made.

3) The name of the patient.

4) The purpose of the disclosure.

5) How much and what kind of information is to be disclosed.

6) The signature of the patient, parent, or other authorized person as required under the regulations.

7) The date on which the consent is signed.

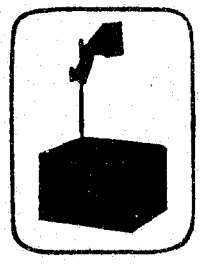
8) A statement that the consent is subject to revocation at any time except to the extent that the program or person who is to make the disclosure has already acted on it.

9) The date, event, or condition upon which the consent will expire if not revoked before. This can be no longer than reasonably necessary to serve the purpose for which is given.

The earlier regulations placed limitations on programs concerning to whom patients could authorize release of information. These limitations are now removed. Patients may authorize release of their records to any individual or organization and may authorize programs to have unrestricted communication with other programs.

- SPECIAL CONDITIONS

There are several other points to consider when dealing with the disclosure of confidential information. Display Overhead 72.



OVERHEAD
72

SPECIAL CONSIDERATIONS

1) DEFICIENT FORMS. Any disclosure form which on its face substantially fails to meet the requirements cannot be honored.

2) REDISCLOSURE. Each disclosure must be accompanied by a written statement indicating that redisclosure of the information is not permitted unless the original consent authorizes it. This is a revision from the earlier regulation.

Point out that the new redisclosure form can be found on page 70 of the participant's manual. All patient material released must have this statement attached to or stamped on the material.

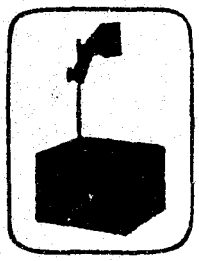
"This information has been provided to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains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

20 Minutes

5. Required Information for Criminal Justice Releases

Explain that special provisions for the release of information apply in cases where a client has involvement with elements of the criminal justice system. The new regulations make it easier for programs to share information with justice.

A program may disclose information about a patient to those persons within the criminal justice system who have made participation in the program a condition of the disposition of any criminal proceeding against the patient. All previously noted conditions for the written release of information apply unless otherwise noted below. Have participants refer to page 71 in the participant manual. The disclosure must meet all of the following conditions:



OVERHEAD
73

Differences in Criminal Justice Releases

(1) To Whom Released

- Those persons within criminal justice system who have a need for information in connection with their duty to monitor patient's progress

(2) Duration of Consent

- Release must state period in effect
- Reasonable taking into account length of treatment and type of criminal proceeding
- No longer subject to 60-day or change in status limitation

(3) Revocation of Consent

- Once given cannot be revoked
- State when revocable, i.e., set time or event

(4) Redisclosure

- May redisclose to carry out official duties

Embellish the issues raised in the overhead by covering the following points:

- CONSENT AUTHORIZED

  Release may be made to those persons within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress in treatment. Those persons include prosecutors, court officials, and probation and parole officers.

- DURATION OF CONSENT

  The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

  - the anticipated length of treatment;
  - the type of criminal proceeding involved, the need for the information in connection with the final disposition of the proceeding, and the date of final disposition; and
  - any other pertinent factors.

Releases no longer are subject to the 60-day time limit or change in legal status provision.

- REVOCATION OF CONSENT

  A written consent must state that it is revocable upon the passage of a specified time period time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be not later than the final disposition of the conditional release or other action in connection with which the consent was given. Once a consent for release is given, it may not be revoked until the specified time or event has passed.

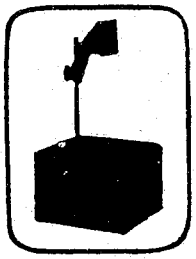
- REDISCLOSURE

  A person who received patient information in connection with criminal justice system involved patients MAY redisclose and use it only to carry out the person's official duties with respect to the authorized release.

When a patient has signed a release of information to someone within the criminal justice system, for example, a probation officer, explain that TASC staff may discuss client progress, attendance, urinalysis results, etc., with anyone within the criminal justice system who has a legitimate need to have the information. This includes prosecuting attorneys. Even if the client leaves treatment, the information may be discussed, providing there was a valid release covering the time period in which the client was involved in treatment or TASC.

The above provision applies, however, only if the client's participation is a condition imposed by the criminal justice system. For example, take the case of a person on probation who voluntarily seeks treatment but is not referred by or otherwise required to attend treatment by the criminal justice system. In this case, the patient's records are not treated as though the client has criminal justice system involvement.

The following is a visual look at the differences between the general release form and those points that change with a criminal justice release this information is found on page 72 of the participant manual. Display this overhead and review the differences.



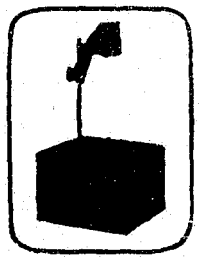
OVERHEAD 74

general release	***criminal justice release***
1. Person to make disclosure	1. Person to make disclosure
2. Name/organization disclosure is to be made	2. Those in justice system with need to know
3. Name of the patient	3. Name of patient
4. Purpose of disclosure	4. Purpose of disclosure
5. How much/what kind of information to be released	5. How much/what kind of information to be released
6. Signature of patient and/or parent	6. Signature of patient and/or parent
7. Date consent signed	7. Date consent signed
8. Statement release can be revoked	8. Once given, cannot be revoked
9. Date/event when release will expire	9. State period in effect

10 Minutes

6. Disclosure Without Patient's Consent

The regulations permit disclosure without patient consent in the following circumstances:



OVERHEAD 75

Disclosure Without Patient's Consent

- suspected child abuse or neglect
- crimes on program premises or against program personnel
- medical emergencies
- research activities
- audit and evaluation activities
- qualified service organizations
- court orders

Go over each exception, emphasizing the following points:

- REPORTS OF SUSPECTED CHILD ABUSE AND NEGLECT

  Reports of suspected child abuse and neglect may be made without violating the regulations (NOTE: this is a change in the regulations). Applicable state law concerning such reporting applies. Disclosures may not be made from client records for use in any civil or criminal proceedings.

- CRIMES ON PROGRAM PREMISES OR AGAINST PROGRAM PERSONNEL

  The restrictions on disclosure do not apply when crimes on program premises or threats against program personnel occur. Only objective information may be released in these instances.

- MEDICAL EMERGENCIES

  Disclosures may be made when an immediate threat to the health of any individual requires immediate medical intervention.

- RESEARCH ACTIVITIES

  Qualified researchers may have access to otherwise confidential patient information, provided that no redisclosure of confidential information occurs.

- AUDIT AND EVALUATION ACTIVITIES

  Any Federal, state, or local governmental agency that provides financial assistance to a program or is otherwise authorized by law to regulate its activities may have access

to patient information. Third party or other payers conducting reviews, including peer review organizations performing utilization or similar reviews, and Medicare or Medicaid auditors may also have such access. No redisclosure by auditors is permitted.

- QUALIFIED SERVICE ORGANIZATION

  Programs may enter into a written agreement with an individual or organization to assist the program in meeting its objectives, such as for data processing, bill collecting, training, etc. Disclosure may be made to the qualified service organization. No redisclosure is permitted by the qualified service organization.

- COURT ORDER

  Disclosure may be ordered by a court of competent jurisdiction provided the procedures outlined in the regulations are followed. These are detailed in the next section.

20 Minutes **7. Court Orders**

Point out that court orders may be used to release client information. Separate procedures and requirements apply depending upon whether the purpose for the release is non-criminally related or related to the investigation or prosecution of patients. Strongly encourage participants to learn the requirements related to court orders. They should be encouraged to read the regulations themselves in Subpart E, Sections 2.61 through 2.65.

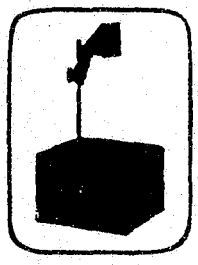
The regulations further discuss the procedures for obtaining court orders related to the investigation or prosecution of programs and program staff, and the placing of undercover agents or informants in programs. These rare situations will not be discussed. Participants should be referred to the regulations for the specific procedures.

Point out that a court under these procedures may authorize the disclosure of "confidential communications" made by a patient to a program. This is a change from the previous rule that limited disclosure to "objective" information.

A discussion of the following key facts will help participants understand not only the mechanics of court orders, but also give them an understanding of the legal principles and issues related to them.

- REQUIRED CONDITIONS

Any court order issued under the regulations may be made only if one or more of the following conditions are met.



OVERHEAD
76

CONDITIONS FOR COURT ORDERS

- THREAT OR HARM
- EXTREMELY SERIOUS CRIME
- LITIGATION

Take a few minutes to elaborate on each condition by emphasizing:

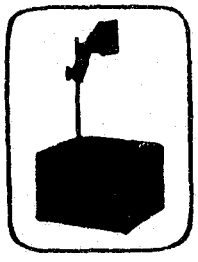
- THREAT OR HARM. The disclosure is necessary to protect against an existing threat to life or serious bodily injury, including verbal threats against third parties and suspected child abuse or neglect.

- EXTREMELY SERIOUS CRIME. The disclosure is necessary in connection with an extremely serious crime, such as one that directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect.

- LITIGATION. The disclosure is in connection with litigation or an administrative proceeding or when the patient offers testimony or other evidence pertaining to the content of the confidential communication.

- PROCEDURES AND CRITERIA FOR ORDERS FOR NON-CRIMINAL PURPOSES

  Overhead 77 reviews the five steps that should be followed for obtaining a court order.



OVERHEAD
77

court order steps

1) APPLICATION
2) NOTICE
3) HEARING
4) CRITERIA
5) CONTENT OF THE ORDER

Explain each of the steps by elaborating on:

- APPLICATION. The court is petitioned for the release of certain information.

- NOTICE. Notice is given to the patient and the program having the information. An opportunity is given to respond to the applications.

- HEARING. A hearing must be held in the judge's chambers or in a manner that ensures that patient's identifying information is not released to third parties, unless the patient requests an open hearing. The judge may review the records in question.

- CRITERIA. The court weighs the potential benefits of the release against the potential harm to the patient or treatment services. The court must also determine that other ways of obtaining the information are unavailable or if available would not be effective.

- CONTENT OF THE ORDER. The court order must limit disclosure to those parts of the record that are essential to fulfill the objective of the order and to those persons with a need for the information.

- PROCEDURES AND CRITERIA FOR ORDERS FOR INVESTIGATORY OR PROSECUTORIAL PURPOSES

  Point out that these steps are carried out somewhat differently when seeking a court order for investigatory or prosecutorial purposes.

  - APPLICATION. The court is petitioned by the person holding the records or by the investigatory or prosecutorial agency.

  - NOTICE. The program having the record must be given adequate notice, an opportunity to respond to the application, and the opportunity to be represented by counsel.

  - HEARING. The hearing must be held in the judge's chambers or in some other manner that ensures that patient identifying information is not released to third parties. The judge may review the records in question.

  - CRITERIA. For a court to authorize the disclosure of confidential information to conduct a criminal investigation or prosecution of a patient, ALL of the following criteria must be met:

a) The crime is extremely serious. Examples were cited previously.

b) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

c) Other ways of obtaining the information are not available or would not be effective.

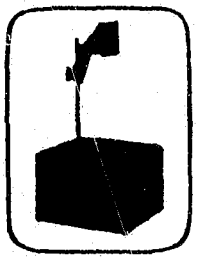
d) The potential injury to the patient-counselor relationship and the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

- CONTENT OF THE ORDER. The court order must limit disclosure to those parts of the record that are essential to fulfill the objective of the order and to those persons with a need for the information. Limitations are placed on investigators and prosecutors so that the information may be only used with respect to extremely serious crimes.

20 Minutes **8. Responding to Subpoenas and Search Warrants**

Point out that it is best if programs have ready access to legal counsel. In the absence of an attorney, the following comments should be helpful to participants. Inform them that since you are not an attorney, the information you are providing should not be substituted for competent legal counsel.

Each program should establish appropriate procedures for responding to subpoenas and court orders. The staff should be advised that any subpoena or court order be referred to the program director or designee. This procedure would eliminate concern and confusion among other program personnel and minimize the chances of unnecessary or unauthorized disclosure of patient identifying information. Overhead 78 highlights the major points regarding subpoenas and search warrants.



OVERHEAD 78

SUBPOENAS

SUBPOENAS

WHAT IS A SUBPOENA

RESPONDING TO A SUBPOENA

DETERMINING IF SUBPOENA IS VALID.

OBJECTING TO A SUBPOENA

RESPONDING TO SEARCH WARRANTS

RESPONDING TO CLIENT ARREST WARRANTS

- WHAT IS A SUBPOENA?

A subpoena is a written order issued by an officer of the court, such as a lawyer, clerk of the court, prosecutor, or judge. One can be issued in connection with any administrative, civil, or criminal proceedings.

There are two kinds of subpoenas. One kind requires a person to appear or give testimony. This is usually a "witness" subpoena or a subpoena for "deposition." The other type, a "subpoena duces decum," requires a person to produce records, documents, or other things which are identified in the subpoena.

- RESPONDING TO A SUBPOENA

The Federal regulations are specific. Confidential information may not be turned over until a valid court order is obtained. A subpoena alone is not sufficient to compel disclosure even if it is signed by a judge.

In cases where a TASC staff member receives a subpoena to testify at a deposition or hearing, or is ordered to produce records, the subpoena is valid if there is a valid consent to report confidential patient information to the criminal justice system. A court order is not necessary in this case.

- HOW TO DETERMINE IF A SUBPOENA OR COURT ORDER IS VALID

The Federal regulations require that programs have an opportunity to respond before an order can be issued to release confidential information, unless, of course, there is a valid consent for the release of information.

The regulations also require that a special "good cause" hearing be held pursuant to 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and 42 CFR Part 2, if there is no written consent. Thus, unless the program received notification that a court order was being sought and a special hearing held, any order requiring the release of confidential information is not valid. If this occurs, consult an attorney as soon as possible.

- OBJECTING TO A SUBPOENA

It is extremely important not to ignore a subpoena, regardless of whether it appears to be valid. First and foremost, obtain legal counsel. In the absence of such counsel, the following recommendations should prove helpful.

- Speak with the attorney who issued the subpoena and explain the applicable Federal confidentiality regulations. Such explanation is especially necessary in situations where a prosecutor or investigator is attempting to obtain information unrelated to a criminal justice system referral. Try to act in a non-adversarial manner by offering to "walk" him/her through the "complex" Federal requirements.

- Try to persuade the person who signed the subpoena to withdraw it.

- If the matter is non-criminal, speak with the patient or the patient's attorney, and see if one of them will voluntarily consent in writing to the release of the information.

- If the matter is related to the prosecution or investigation of a patient, inform the individual of the regulations and the need to seek a special court hearing before the information can be released.

  The above conditions do not apply if the investigation is related to a patient's failure to follow an order to be diagnosed or treated for alcohol or drug abuse, providing there was a valid consent.

- Send a written response to the person who issued the subpoena, with copies to the judge and other attorneys who may be involved. Object to the subpoena, setting forth the reasons for the objection. It is good practice to enclose a copy of the relevant portions of the Federal regulations.

- If you are forced to appear, based on what seems to be an improper order, ask the judge for a one- or two-week adjournment, and for time to obtain legal counsel. Show the judge the regulations.

- HOW TO RESPOND TO A SEARCH WARRANT

Only under extremely rare conditions would a substance abuse program be served with a search warrant. In the unlikely event this occurs, consider the following:

- Try to delay the seizure. Inform the officer that the judge did not have authority to issue the search warrant under Federal laws and regulations. Show the officer the regulations and ask that you be given the opportunity to contact your attorney before the records are seized.

- Request that the officer leave.

- Contact your attorney immediately.

- If these steps don't work, ask the officer to allow you time to contact the judge before the records are seized. Call the judge. If you can't reach him or her, contact the officer's supervisor if possible.

- If seizure is inevitable, request that the records be placed in a sealed envelope.

- Make a full report as soon as possible to the National Institute on Drug Abuse and the proper state authority to determine whether the incident should be referred to the U.S. Department of Justice for possible prosecution. You do have the option of referring the matter directly to the local U.S. Attorney.

• RESPONDING TO CLIENT ARREST WARRANTS

If there is a warrant for the arrest of your client and the client is present at your facility, you must turn the client over to the arresting officer. If the client is not present, you are under no obligation to give the police any information until a special court hearing takes place.

30 Minutes **9. Confidentiality Exercise**

The purpose of this exercise is to help participants integrate the material on confidentiality that has been presented. Start by dividing the participants into groups of eight. Assign each group one of the cases on pages 74-75 in the participant manual. Ask the groups to read the case, reach a consensus on how they would handle the situation, and then prepare to justify their methods. If time permits, assign additional cases to those groups finishing early. These cases are included at the end of this module. Each case has an answer. This should help the trainer in clarifying the correct response to the issue.

Allow approximately 15 minutes for the groups to discuss their cases. Ask each group to choose a spokesperson who will read the case, state the recommended action, and then justify the action. Allow the other participants to question or disagree with the recommended course of action.

5 Minutes **10. Summary**

Summarize the model by reminding the participants that the confidentiality regulations are a tool to assist in their work with clients. The regulations provide protection to both the client and the program. However, it is important to caution the participants not to use the regulations to keep information from the criminal justice system. Unless the regulations are followed allowing for reporting back on client progress, the whole TASC concept will collapse due to lack of communication.

Refer them to pages 76-80 in the participant's manual. This question and answer section addresses the most common confidentiality questions asked by TASC staff. Also pages 81-100 in the participant manual are a copy of the Federal Confidentiality Regulations. Notify participants of the Legal Action Center in New York City. The center has a staff of lawyers trained in the regulations. Programs might benefit from becoming a subscribing agency and thus have immediate telephone access to a lawyer. For more information, suggest they call the Legal Action Center at 1-800-223-4044. The center also publishes a newsletter Of Substance, which is published six times a year and covers drug and alcohol confidentiality and employment issues.

This would be an excellent time for a break.

Case Studies

CASE #1

A counselor in an alcohol and drug abuse outpatient clinic indicated that she will resign at the end of the month.

As Program Director, you are concerned about protecting confidentiality of all oral and written patient information to which this staff member has access. Develop appropriate procedures to ensure confidentiality.

Answer: At the time of hiring, all new staff should receive in writing a summary of the provisions of 42 CFR Part 2. Inform (or remind) the counselor that the confidentiality provisions of 42 CFR Part 2 apply to all current and former staff, and covers not only written records but all oral communication as well. Review your current procedures to assure that only staff with a bona fide "need to know" have access to client written records (e.g., records are kept in a secure room, only designated individuals have access to the room, a sign-in and sign-out log is maintained, a written entry is made into a client's record whenever it is reviewed). You may also want to remind other staff of the overall need to maintain client confidentiality.

CASE #2

A student was suspended from all classes pending treatment for an apparent drug problem. He enrolled in the treatment program.

After completing the necessary treatment, the student sought readmittance to high school. The principal now requests a report on his treatment and progress in the program.

Answer: This report can only be made if there is a valid written release. In those states where a minor can consent to his or her own treatment, the minor must sign the release. In all other states, the responsible parent or guardian must sign the release.

CASE #3

Two investigators from the FBI and the Defense Intelligence Agency have appeared at your office seeking information on a former client who had a long history of both criminal offenses and substance abuse treatment failures. They claim the client has applied for a job requiring top secret clearance, hence the investigation. They also claim Federal law authorizes them to get whatever information is necessary to conduct their investigations.

The investigators also claim they believe the client was seen in your program because they found a seven-year-old court order mandating the client to attend your program. What would you do?

Answer: Ask the agents if they have a written release signed by the individual. If not, they should be shown a copy of the Federal law (42 U.S.C. 290ee-3) which prohibits the release of any client information without the written consent of the individual. The law appears in the revised Federal Confidentiality Regulations (June 9, 1987 Federal Register, page 21804). Explain that the easiest way to get the information they request is by having the individual sign a release. Give them a release form, as well. Also explain to the agents that in the absence of written client consent, they must seek a "good cause" court hearing as described in Sections 2.61-2.64 of the confidentiality regulations to obtain the information they require. Show them a copy of the regulations, if needed.

CASE #4

Seventeen-year-old Brad, who was convicted as an adult after his third felony drug charge, was assessed by TASC, referred and admitted to a day care program. His mother is calling to find out if Brad is attending treatment, since he hasn't been home in two days and she's extremely concerned.

Your records don't seem to have a release from Brad to speak with mother, but you think he did sign one with the treatment program. Unfortunately, his counselor is not available. What would you do?

Answer: In this case it is best to refer the parent to the treatment program if TASC does not have a properly signed release. Where state law allows a minor to receive treatment without parental consent, then the information can be given only with written client consent authorizing release to the parent. If state law requires parental consent in order for a minor to receive treatment, then the information could probably be shared with the parent, providing it is known that it actually is the custodial parent who is calling.

CASE #5

An Assistant State Attorney investigating a double homicide calls you stating that one of your TASC clients is a suspect. He has been unable to locate the client and wants you to tell him the client's address. The State Attorney is insistent that unless you give him the information he wants, he will have you arrested for obstruction of justice. What do you do?

Answer: Do not release the information. Explain that you want to fully cooperate, but that Federal law (42 U.S.C.290ee-3) and Federal regulations (42 CFR Part 2) prohibit the disclosure of the information sought without a special "good cause" court hearing. Explain the procedures of Section 2.65 ("Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients" found on page 21813, Federal Register, June 9, 1987) and offer to give the prosecutor copies of the law and regulations. If the prosecutor is still insistent, you can ask him to subpoena the information. When the subpoena is received, an objection should be filed. If all else fails, seek legal counsel immediately.

CASE #6

You have received a telephone call from the father of a 20- year-old client who is being seen this evening in outpatient group counseling. The father wants to know if his son has left the program because he needs to speak with him on the phone. What do you say?

Answer: Unless there is written consent to speak with the father, no information should be given out. One way around this frequent problem is to tell the father that you do not know if his son is there, or even if his son is a client, but you will take a message and pass it on. This way, the son can decide whether or not to call his father, if the son is a client.

CASE #7

A former client was dropped from TASC because he had dirty urine and discontinued treatment. He is now in violation of parole and you are presenting testimony about him in court. While on the stand, the judge asks you to tell him about the client's childhood, his drug history, whether he had ever admitted to doing any crimes for which he was never arrested. You have the information. What do you say?

Answer: If the client has offered testimony regarding these questions, then you are clearly permitted to answer them (Section 2.63). Otherwise, hope the client has a good attorney who will object to the question. If no objection is made, respectfully tell the Judge that you believe that certain Federal restrictions may apply to you answering the questions in open court. Request an opportunity to explain and show the Court Subpart E ("Court Orders Authorizing Disclosure and Use") of the Federal regulations. If this does not work, answer the questions under protest. Then, seek legal counsel.

CASE #8

A client who is enrolled in methadone maintenance was injured in an accident on his construction job last year. The client applied for worker's compensation insurance because he has $2,500 in medical bills and missed three weeks of work. The insurance company refuses to pay, claiming that he was a drug addict and that he was on methadone. The insurance company is claiming that the methadone was the cause of the accident.

You have now received a subpoena from the insurance company to verify that the client is on methadone. The company is also asking for a complete copy of his treatment records. How do you respond?

Answer: The easiest way out of this situation is if the client will sign a release of information for the insurance company. Therefore, inform the client that you have received the subpoena, and ask him to consult with his attorney concerning signing a release, specifying what information is to be disclosed. Once a release is signed, the requested information can be released. Do not release the entire record.

If the client does not sign a release, object to the subpoena in writing, explaining to the insurance company that the information is protected under Federal law and regulation (42 U.S.C. 290ee-3 and 42 CFR Part 2). The requested information can only be released after a "good cause" court hearing has been held pursuant to 42 CFR Part 2, Subpart E, Sections 2.61-2.64. Enclose a copy of the regulations with your objection.

MODULE XII: SPECIAL POPULATIONS

TOTAL TIME: 1 hour 40 minutes

PURPOSE

This module is designed to acquaint TASC program staff with issues surrounding application of the TASC model to the following populations: adolescent offenders, DUI offenders, chronically mentally ill offenders, and perpetrators of family violence.

OBJECTIVES

By the end of this session, participants will be able to:

- Provide through written examples three elements of the TASC model which correspond to the needs of adolescent offenders and the juvenile justice system
- Provide through written examples three elements of the TASC model which correspond to the needs of DUI offenders
- Provide through written examples three elements of the TASC model which correspond to the needs of the chronically mentally ill
- Provide through written examples three elements of the TASC model which correspond to the needs of perpetrators of family violence

MATERIALS/RESOURCES NEEDED

Overhead Projector
Overheads
Markers
Participant Manuals
Masking Tape
Flipchart Stand/Paper

MODULE XII: SPECIAL POPULATIONS

TIME/MEDIA & MATERIALS:	outline of training activities

5 Minutes

1. Introduction Lecture/Discussion

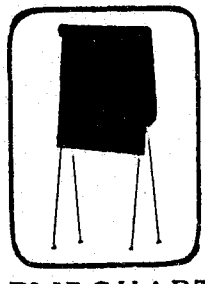
The TASC program model was originally created to deal with a narrowly defined population the opiate abusing criminal offender. Time and experience proved that the program model had broader application. Thus, eligibility criteria were widened to include all drug or alcohol abusing offenders. The TASC program model can also be successfully utilized to intervene with other client populations if the critical elements fundamental to TASC are maintained. TASC can serve the following populations:

- juveniles
- DUI offenders
- mentally ill offenders
- perpetrators of family violence

While there is a danger of diluting program resources and focus, most programs serving these select populations have avoided those pitfalls through careful planning and attention to the special needs/issues of the new client group.

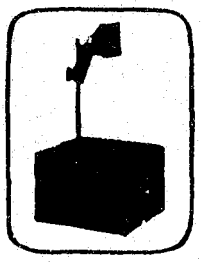
20 Minutes

2. Special Population Considerations



FLIPCHART

At this time put up one flipchart sheet for each special population group: juveniles, DUI, mentally ill offenders, perpetuators of family violence. Ask all trainees to take a marker and write on the flipcharts, noting differences between historic TASC clientele and each of the four special population groups. Ask them to record special issues or problems TASC would have to consider if they were going to work with this population. Once all participants have had a chance to list their issues, go back to each of the four charts, acknowledging points noted by trainees. Once you have acknowledged the audience responses on each population display the overhead that corresponds to that population and reiterate and summarize issues that must be considered when working with that group. Be sure to explain all elements listed on the flipchart. Refer participants to page 102 in their manuals.



OVERHEAD 79

adolescents

Time between arrest and adjudication

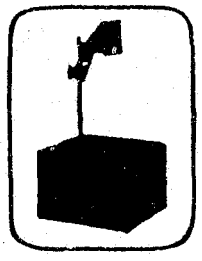
Infrequent detention

No bail system

Family dynamics greater

Assessment/treatment must include family

Infrequent drug dependence



OVERHEAD 80

DUI offenders

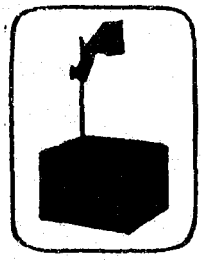
Independent DUI evaluation/treatment network

Monitoring of alcohol use

Monitoring ingestion of antabuse

Occurs in traffic court

Potential duplication in DUI system of assessment and referral



OVERHEAD 81

mentally ill offenders

Greater potential for violence

Greater expertise needed in assessment/case management

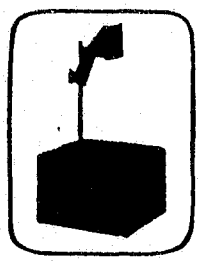
Need for small tracking caseload

Use of urinalysis to validate use of prescribed medications

Totally different treatment system

Need for more extensive linkages with social service agencies

Use of civil commitment procedures



OVERHEAD 82

family violence

Need for specialized treatment program designed to stop violent behavior

Frequent denial/minimizing of violent behavior by client

Potentially violent clientele

More intensive assessment of family issues warranted

Victim involved

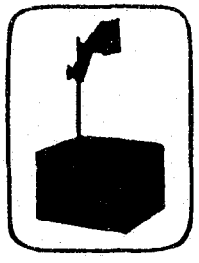
15 Minutes

3. Case Profiles and Special Considerations: Juveniles

Trainer Note: Each of the next four sections begins with a case profile. Ask the participants to read the profile and then answer the question at the bottom of the page which asks them to list special issues in intervening effectively with this client. allow five - ten minutes for this task. Once completed facilitate or group discussion on the case. Now finish each section by highlighting the special considerations for a TASC program in working with this population. For trainer reference, the four case profiles are at the end of this module.

Now we are going to discuss how TASC programming needs to be adjusted in order to deal effectively with these distinct populations. Lets begin by reading the juvenile case profile on page 103 of the participant manual. Once you have read the description answer the question at the bottom of the page.

Facilitate a discussion on the participants observations on how TASC should effectively handle this client. When you have finished processing the participants ideas display overhead 83 which highlights key TASC elements with juvenile cases.



OVERHEAD 83

Key TASC ELEMENTS: *JUVENILES*

Intervention Points

Identification and Screening

Eligibility Criteria

Intake Interview

Referral

Case Management

Confidentiality

Juvenile vs. Adult Clients

Discuss each point mentioned in the overhead being sure to cover:

- Intervention Points: Because the juvenile court system differs greatly from the adult court system, TASC staff should recognize some unique possible points of intervention. Possible sources of juvenile referrals include the intake staff at the juvenile detention facility, the juvenile probation staff, and the juvenile court. Other sources come from the judiciary, the prosecuting attorney, public defender, and other juvenile service programs.

- Identification and Screening - In screening potential clients, TASC staff should interview the juvenile before the initial court appearance (if there is to be a formal court proceeding) or as soon after the intake interview as possible. TASC staff should also interview the parents to ascertain their willingness to allow their child to become a TASC client and participate in treatment. During the screening interview, the TASC worker should also ascertain whether the parents are willing to participate in treatment. Have the child and the parents sign the release of information. TASC staff should also consult with the defense attorney or public defender.

- Eligibility Criteria - Eligibility criteria for TASC projects accepting juvenile clients may need to be altered in terms of minimum age, pending charges, length and degree of substance abuse, and the types of drugs abused. TASC may wish to assume a role and accept juvenile clients who are in the early stages of substance abuse. Care should be given to discriminate between normal adolescent experimentation and full-scale substance abuse. Additionally, programs should avoid "net widening," which may occur if dependency cases are allowed in the system. This is best accomplished by determining the client's past history, any treatment outcomes, and other incidents within school or law enforcement purviews.

- Intake Interview - TASC staff may choose to alter somewhat the structure of the intake interview, beginning with a brief overview of TASC, the client's obligations, and an explanation of confidentiality, during which both the juvenile and parents should be present. Next, the staff person may conduct an in-depth needs assessment interview with the parents while the adolescent is in the waiting room.

  The content of the intake interview may also be altered. TASC staff should decide whether parents will accompany their child to the interview and whether parents and adolescents are to be separated throughout the interview process. Assurances should be made that the information revealed will be kept confidential and not revealed to other family members. The interviewer may wish to discuss nonthreatening topics first to

help gain the adolescent's confidence and trust. During the interview, care should be taken to examine closely all significant facets of the adolescent's life, being sensitive to detect "life problems" (socializing, self esteem, inter-family relationships, etc.) that may be manifested.

- Referral - The range of treatment modalities available to the adolescent is generally wider than that available for adults. In addition to traditional substance abuse programs, TASC may consider referring the juvenile client to family counseling, Families Anonymous, etc. While the range of available referral options may be wider, locating treatment programs having expertise in dealing with substance abusing adolescents who are involved with the criminal justice system may be more difficult. Consult with local alcohol, drug abuse and mental health case managers to determine availability of programs.

- Monitoring - Monitoring adolescents differs from monitoring adult TASC clients. Adolescent clients are usually more closely monitored than adults, and the TASC trackers usually have more frequent contact with the treatment counselors.

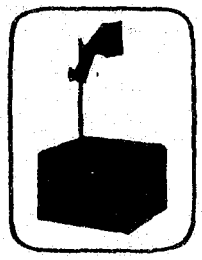
- Confidentiality - TASC staff need to be especially well informed regarding client confidentiality issues unique to juvenile patients' information. These issues include, but are not limited to, parents' access to client records, the issue of consent to treatment, and the need for parent's consent to release of client information.

- Juvenile Clients vs. Adult Clients - TASC projects that accept juvenile clients have found some general differences between adolescent and adult clients. Juvenile clients are often more time consuming; for example, the needs assessment interview is more extensive. Their life problems may be more complex. Family involvement is often essential. Not only must the family see the need for treatment, but it should be encouraged to participate in treatment when possible. TASC staff have found that they often have less clout with the juvenile court system, although that system looks more favorably to diversion. Juvenile clients are often involved with TASC for a shorter period of time.

15 Minutes **4. Case Profile and Special Considerations: DUI**

Ask the participants to read the DUI case found on page 104 in the participant manual. Once finished ask them to list any special issues TASC needs to be in tune with when intervening with this client.

Once again facilitate a discussion on the participants observations. Finish this section by displaying overhead 84 which highlights key TASC elements with DUI cases.



OVERHEAD
84

Key TASC ELEMENTS: *DUI CASES*

Intervention Points

Screening/Identification

Assessment/Referral

Case Management

Success/Failure Criteria

Discuss each item in the overhead highlighting the following points:

- Intervention Points - In most instances, DUI offenders are referred to TASC by the court rather than as a result of earlier TASC intervention. Judges may see TASC as their only resource for a repeat chronic DUI offender.

  In most states, a referral/evaluation/education mechanism has been developed to deal with the DUI offender. TASC staff should be knowledgeable of that system and its resources. There is a high potential for duplication of effort, which should be addressed in formal written agreements.

- Screening/Identification

  Some key issues to consider are breaking through denial and use of alcohol screening tests such as the Michigan Alcoholism Screening Test, John Hopkins Self-Administered Test, Alcadd Test, etc.

- Assessment/Referral

  Issues to consider are using family as a resource, key questions to ask the client, detection of "life problems" that manifest use of alcohol or drugs, interviewing techniques including the need to break through denial and keying in on evident symptoms caused by drinking (physical, psychological, social, behavioral symptoms). The range of available treatment services are often different for this population.

- Success/Failure Criteria

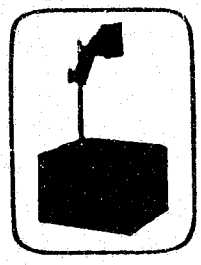
  Issues to consider are difficulties in obtaining objective information (refer back to urinalysis module), use of significant person's report, attendance slips from AA meetings, and the need to monitor antabuse ingestion.

15 Minutes

5. Case Profile and Special Considerations: Mental Health

Instruct the participants to read the mental health case profile found on page 105 of the participant manual. As before, ask them to list any special needs for TASC in order to effectively intervene with this client.

For variety, ask the participants to pair off with another individual. Instruct them to discuss the case and the issues they surfaced. Allow four minutes for this task. Now facilitate large group discussion regarding these issues. Complete this section by displaying overhead 85.



OVERHEAD 85

Key TASC Elements: *MENTAL HEALTH*

criminal justice relationship

treatment relationship

client identification/screening

assessment/referral

case management

Discuss each item on the overhead highlighting the following points:

- Criminal Justice Relationship

  The court system is frequently much more at a loss in attempting to process chronically mentally ill offenders than any other population. The general ignorance of mental illness carries over from the general population to criminal justice, corrections, and treatment providers. Mental illness often carries with it the need to educate. There is also a heavy responsibility in presenting TASC to the courts as capable of supervising the chronically mentally ill. There are often very few resources available that will provide services to this population, thus once a commitment is made, a program can expect heavy use. More than one percent of the general adult population suffers from schizophrenia, and it is the primary diagnosis within state treatment facilities. One of the unfortunate by products of deinstitutionalization of the mentally ill has been a concomitant rise in the number of mentally ill persons entering, and becoming dependent upon, the justice system.

- Treatment Relationship

  It is not appropriate to work with mentally ill offenders without documented policies and procedures for securing the services of the full range of mental health treatment service beginning with crisis stabilization through indefinite domiciliary care. The available continuum of care in your region should be examined.

- Client Identification/Screening

  Under general conditioning TASC programs will screen out the chronically mentally ill. Thus modifications in eligibility criteria must be made to accommodate this population. These individuals are highly likely to be screened by TASC in the county jail, with psychotic symptoms in remission, indicating the need to carefully assess medical history and mental status. Further, it will be rare for a TASC screener to be the first to identify a mentally ill person. Treatment records are likely to exist if a full treatment history can be elicited from the client, the jail, or forensic facility.

- Assessment/Referral

  Unless the program has trained staff in social work or psychology, it is appropriate to consult with these staff before assessment so that early development of a plan can occur with all concerned disciplines.

- Case Management

  Chronically mentally ill clients demand a great deal of time from project tracking staff because of their heavy needs for linking and advocacy with criminal justice, mental health, and social service personnel. Staff responsible for monitoring mentally ill clients should experience a reduction in overall caseload.

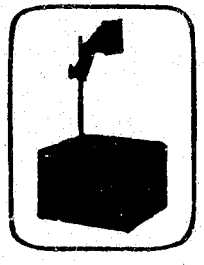
You may want explore some additional questions with the group. Pose each question and solicit group discussion around the issue.

- What is the capacity in the region to handle the dually diagnosed mentally ill/substance abusing client
- What programs within the region are funded to provide outpatient treatment to forensic clients
- Is there a forensic facility in the region that provides outreach services
- Has the court ordered special conditions of treatment by the court
- Does the court administrator or probation and parole office have any vested interest in this client

15 Minutes **6. Case Profile and Special Considerations: Family Violence**

Ask the participants to read the family violence case found on page 106 of the participant manual. Once finished ask them to list any special issues TASC needs to be in tune with in order to intervene effectively with this client.

Facilitate a discussion on the participants observations. Finish this section by displaying overhead 86 which Highlights the key TASC elements with family violence cases:



OVERHEAD 86

Key TASC ELEMENTS: *FAMILY VIOLENCE*

CRIMINAL JUSTICE RELATIONSHIP

TREATMENT RELATIONSHIP

CLIENT IDENTIFICATION/SCREENING

ASSESSMENT/REFERRAL

CASE MANAGEMENT

Summarize the points raised in the overhead by emphasizing the following:

- Criminal Justice Relationship

  Many jurisdictions attempt to dispose of family violence cases through arbitration or pre-trial diversion programs, frequently supervised through the state attorney's office. Special conditions by the court require consultation by TASC program staff.

- Treatment Relationship

  To intervene in this area, there must be a designated person who possesses the expertise to provide therapy specifically for the treatment of domestic violence.

- Client Identification/Screening

  Clients will frequently be identified at point of arraignment or diversion. Eligibility criteria must allow for this type of client, particularly if there is no evidence of substance abuse.

- Assessment/Referral

  Intake staff must closely assess need for substance abuse counseling. When indicated, decision making is required around which issues to address and in which order.

- Case Management

  Similar to other TASC clients, the case management of this client may require developing new linkages with treatment providers and education of the TASC case managers in the goals of family violence treatment.

5 Minutes **7. Summary**

As you have moved through this module, you have seen how the TASC elements of criminal justice relationships, treatment relationships, client identification/screening, assessment/referral, and case management are transferable to varying populations within the justice system. This transferability alone shows TASC to be an effective program. In an effort to maintain its effectiveness and credibility, the elements and resources must remain consistent throughout program development. Special client populations bring with them special needs and considerations that we have seen to be different from TASC's historic clientele. However, we have also seen that by keeping within the framework of the TASC Critical Program Elements, in conjunction with a careful determination of the available talent and resources, special populations may be served.

10 Minutes **8. Course Summary**

This is the final activity. Summarize the entire course by pointing out that the TASC concept is one that has proven effective in intervening with the drug involved offender. This course was designed to overview the essential elements of the TASC program and to teach awareness and skills regarding each of these elements. It is hoped the material presented will help the participants in their TASC responsibilities.

Ask if there are any unresolved issues or questions. Inform the participants that you would like one more thing from them, to complete the post test. Ask them to turn to pages 87-88 in the participant manuals and complete the post test. Instruct them to place on the top of each page the same anonymous code they used for the pretest. Once the test is completed they may leave. Be sure to thank the participants for their involvement in the course and wish them safe travels home.

CASE PROFILE: ADOLESCENTS

A 15 year old girl who attended a public school in a local suburb was referred to TASC. Her school performance was deteriorating from straight A. She was showing up for her gymnastics class too drunk to perform safely. She had frequently missed classes during the previous six months, and was now on academic and social probation. Well liked and previously successful, she had won a civic merit prize for character and academic achievement in sixth grade. Her physician father and both grandfathers were alcoholics, and her mother also drank heavily. The girl has one previous drug treatment experience. At the time of TASC evaluation she was drinking daily, starting with a pint of wine before school. She feels she is unable to stop. When she tries, she becomes shaky and developes rapid heartbeat. She was defensive and frightened about her drinking. Her arrest on the previous weekend for shoplifting a bottle of wine from a convenience store, resulted in her intake into the local juvenile detention center. The girl was also charged with resisting arrest with violence when she became belligerent with the arresting officer. He noted on the arrest report that she appeared to be intoxicated at the time of her arrest.

How would you handle this case?

CASE PROFILE: DUI

Karen Martin is a 32 year old white female ordered/referred to TASC by the county traffic court. She is charged with DUI and numerous other charges resulting from a collision with another car in which the second car was totalled and the driver hospitalized. At the time of arrest, her blood alcohol level was .015. She is married, employed, and has one child. This is her first DUI arrest. She has no criminal history and has never been in treatment. The TASC screener has reviewed this case. Should she become a TASC client?

CASE PROFILE: MENTAL HEALTH

Don is a 24 year old white male carrying a diagnosis of schizophrenia, chronic undifferentiated type, first diagnosed at the age of 17. Don is also known to abuse substances, particularly alcohol and marijuana. He is of borderline intellectual functioning with a full scale IQ of 75. Don's parents are divorced. His father's whereabouts are unknown. His mother and stepfather live in the area but are unable to care for him at home.

Don is currently on medication. Intravenous injections are used to ensure adherence to the medication regime.

Don is frequently preoccupied with devils and the occult. He is often demanding and threatening toward others. He has a history of arrests for trespassing, public intoxication, and battery. He has been barred from the Community Mental Health Center's residential facilities because of substance use and aggressive acts toward other residents and staff. He is eligible for SSD, SSI, and OSS as well as Medicaid, with benefits totalling $520 per month.

He is currently nearing release from a civil psychiatric hospital after serving nearly two years in a state corrections mental health institution, followed by a state hospital for the criminally insane. He remains under the indefinite jurisdiction of the court as a result of being found not guilty by reason of insanity. The judge has asked TASC to coordinate local placement and case management of Don in the community.

The screener interviewed this individual at the psychiatric hospital. How would you handle this case?

CASE PROFILE: FAMILY VIOLENCE

Ronnie, an enlisted Navy man, was arrested for spouse abuse one evening when he became violent during an argument over family finances. He struck his wife several times after which she took their two daughters ages, 1-1/2 and 4, to a local shelter for battered women, informing the shelter that was at least the fifth similar episode. He moved out of the house into the barracks on base and a restraining order was placed on him. Edna, his wife, called him two nights later, sounding intoxicated and claiming to have taken some sort of pills.

Ronnie sent an ambulance to the house, fearing for her safety and that of the children. Upon arriving at the home, the driver found Edna in no danger. When Ronnie arrived, Edna called the police and had him arrested.

The TASC screener interviewed him at the jail and referred him into the program.

How would you handle this case?

APPENDICES

1- PRETEST

2- FREQUENTLY ASKED CONFIDENTIALITY QUESTIONS

3- CONFIDENTIALITY REGULATIONS

4- POSTTEST

PRE-TEST

TASC CRITICAL ELEMENT TRAINING PRE-TEST

1. Name two types of frequently used urinalysis confirmation tests

_____

_____

2. List the three client eligibility criteria generic to most TASC programs.

_____

_____

_____

3. The best metaphor to describe TASC's linkage with criminal justice and treatment is

_____

4. List five of the ten TASC critical program elements.

_____

_____

_____

_____

_____

5. Five of the critical elements may be described as _____, while the other five are described as

_____

6. List 8 common stages in the processing of defendants by the criminal justice system.

_____ _____

_____ _____

_____ _____

_____ _____

7. Two benefits of TASC intervention to the criminal justice system include_____ and _____

8. Formal agreements between TASC and justice agencies should include _____and_____

9. List three major drug abuse treatment program modalities

_____

_____

_____

10. List two barriers to good working relationships between TASC and treatment.

_____

11. List two variables which can effect the development of local eligibility criteria

_____

_____

12. List three components of a TASC screening interview.

_____

_____

_____

13. List six components of an assessment interview.

_____ _____

_____ _____

_____ _____

TASC CRITICAL ELEMENT TRAINING PRETEST

14. List three variables which effect TASC's treatment referral capability

_____

_____

_____

15. Define the term "case management"

_____

_____

_____

_____

16. Describe the most common TASC strategy for assisting clients who are in danger of termination from a treatment program_____

_____

_____

17. List four documents which must be in the client file.

_____ _____

_____ _____

18. Define the term "chain of custody" as it relates to TASC

_____

_____

_____

_____

19. List two types of technology available for urine testing

_____

_____

20. List two differences between a general release of confidential information and a criminal justice release. _____

_____

21. List two situations where information can be released about a client without his/her consent

_____

_____

22. List five of the nine elements of a general release of information

_____

_____

_____

_____

_____

23. Where are confidentiality regulations published?_____

_____

24. List three populations other than adult drug abusers where the TASC model has been proven effective.

_____

_____

_____

25. List two problems associated with urine collection

_____

_____

FREQUENTLY ASKED QUESTIONS

FREQUENTLY ASKED CONFIDENTIALITY QUESTIONS

1. If a client discloses that he has knowledge about a serious crime, for example murder or arson, what should be done? What if the client admits he committed such a crime but was never prosecuted?

   ANSWER: No disclosure can be made by the program without the client's written consent or an authorizing court order (unless it involves child abuse, which must be disclosed in accordance with state law). The program can apply for a "good cause" court hearing which would permit the program to release the information to the proper law enforcement agency. Section 2.63 (a) (2) permits a court to order the release of this kind of information. It is advisable for programs to adopt policies to deal with dilemmas such as this, deciding in advance whether court orders will be sought to disclose information about extremely serious crimes. Clients should be oriented to these policies at admission.

2. If a client threatens to commit a crime, what should be done?

   ANSWER: If the crime is threatened against the program or staff, this can be reported to local law enforcement authorities without violating the confidentiality regulations. If the threat is against a third person, a court order must be obtained in accordance with Sections 2.63 and 2.65 If the threat would result in immediate harm to a person, legal counsel should be immediately obtained. If counsel cannot be obtained, it is probably best to disclose the minimum amount of information necessary to protect the individual's safety. This is commonly known as the "duty to warn."

3. If it is suspected that a client was the victim of child abuse, can this be reported?

   ANSWER: The Federal confidentiality regulations do not provide any protection for cases of suspected child abuse or neglect. All such incidents must be reported in accordance with state law.

4. An agency refers an individual for services. Can requests be answered about whether the referred individual actually appeared?

ANSWER: If the initial referral was made by someone other than the client, the program may answer whether the person referred actually appeared. The program may not disclose whether the individual was admitted to the program, unless there is a signed release of information. If there is a court order for the individual to be seen at a program, whether the person appeared or not may be reported to the appropriate court officer (e.g., probation department).

5. Must I surrender my records to a law enforcement officer if I am served with a subpoena?

ANSWER: Section 2.61 states that "The person may not disclose the records (of a client) in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations." Thus, records should never be disclosed pursuant only to a subpoena. If a subpoena is received, an objection should be filed with the individual who authorized it, as well as with the appropriate court.

6. If a client signs a release for information to be disclosed from his record to a third party, must copies also be made available to the client if requested?

ANSWER: The Federal confidentiality regulations are silent on this point. Thus, applicable state law will determine the answer. In some states, based on state statute or case law, clients or patients have the right to inspect or obtain a copy of their records. In other states, this right is not guaranteed. Legal opinion should be obtained to determine local statutes and case law.

7. If a client wants to have a copy of his record, does a release have to be signed?

ANSWER: No. The client does not have to sign a release in order to obtain a copy of his record.

8. A TASC program is part of a mental health clinic, which requires that all client records be kept centrally. Can TASC records be combined with the general records of mental health clients?

ANSWER: Yes. However, the records of TASC clients are still subject to all the requirements of the confidentiality regulations. Section 2.16 requires each program to "adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations." Thus, the mental health center must limit access to TASC records to only those staff with a legitimate reason to view the records.

9. Can confidentiality information be released to a family member by phone, or must it be only in person or in writing?

   ANSWER: There must be a signed release in order for any information to be disclosed. Such disclosure can be made by phone, in person or orally. Be certain that phone disclosures are actually made to the authorized person.

10. If a client has signed a release to his probation officer, how much can I tell over the phone?

    ANSWER: As long as there is a valid release of information, disclosure can be made over the phone. The information to be released is limited by the kind and amount of information specified to be disclosed in the release. The proper form for releases is contained in Section 2.31 of the regulations.

11. If a client makes a request for information to be released from his record, and a release of information is signed, does the program have to release the information?

    ANSWER: The confidentiality regulations do not compel a program to release any information solely based on the client's written request. Thus, the answer to this question will depend on state law. Programs should obtain legal counsel to determine the applicability and interpretation of state law.

12. Can a client's record be brought to court if a staff receive a subpoena to testify in court?

    ANSWER: It is best not to bring a record into court. The person subpoenaed should review the record before court, taking pertinent notes if necessary. If the subpoena is a "duces tecum", then the record should be brought to court.

13. If a person currently under probation applies for drug treatment can the person's probation officer be told?

    ANSWER: No. No information can be disclosed to the probation officer, including the fact that the probationer has applied for treatment, unless the probationer has signed a written consent for the release of confidential information.

14. Can a criminal justice confidentiality release also be used as a release for treatment?

ANSWER: Probably not. While the two releases are similar, they are not identical. Once a criminal justice release is signed, it cannot be revoked until the duration specified in the release is reached. A non-criminal justice release must state that revocation can be made at any time. A criminal justice release also allows redisclosure to those individuals within the criminal justice system who have made participation in TASC or treatment a condition of any criminal proceeding, or who have a need for the information in connection with their duty to monitor the client's progress. The non-criminal justice release does not permit redisclosure unless it is specified in the release.

15. If a client decides to drop out of TASC and revokes his release, can his probation officer be informed that he has been terminated from TASC?

ANSWER: The release for a criminal justice client must state that it is revokable upon the passage of a specified amount of time or the occurrence of a specified event. This means a criminal justice client cannot revoke his release until the specified time or event has been reached. The client's probation officer should be informed if the client drops out of TASC. Programs should be sure their releases conform to the requirements of Subpart C (Sections 2.31-2.35) of the confidentiality regulations.

16. A former TASC client is being violated because he did not complete treatment two years ago. At the time there was a valid release from TASC to the probation officer. The local prosecuting attorney has called asking for information about the client's attendance, urinalysis results and treatment outcome. Can this information be given?

ANSWER: Yes. As long as there was a valid release covering the time while the client was in TASC and treatment, this information can be shared with the prosecutor. Staff can also testify at a hearing or in court concerning this client who failed TASC.

federal register

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June 9, 1987

Part II

Department of Health and Human Services

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records

AGENCY: Alcohol, Drug Abuse, and Mental Health Administration, PHS, HHS.

ACTION: Final rule.

SUMMARY: This rule makes editorial and substantive changes in the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations. These changes are an outgrowth of the Department's commitment to make its regulations more understandable and less burdensome. The Final Rule clarifies and shortens the regulations and eases the burden of compliance.

EFFECTIVE DATE: August 10, 1987.

FOR FURTHER INFORMATION CONTACT: Judith T. Galloway (301) 443–3200.

SUPPLEMENTARY INFORMATION: The "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, implement two Federal statutory provisions applicable to alcohol abuse patient records (42 U.S.C. 290dd–3) and drug abuse patient records (42 U.S.C. 290ee–3).

The regulations were originally promulgated in 1975 (40 FR 27802). In 1980 the Department invited public comment on 15 substantive issues urising out of its experience interpreting and implementing the regulations (45 FR 53). More than 450 public responses to that invitation were received and taken into consideration in the preparation of a 1983 Notice of Proposed Rulemaking (48 FR 38758). Approximately 150 comments were received in response to the Notice of Proposed Rulemaking and were taken into consideration in the preparation of this Final Rule.

The proposed rule made both editorial and substantive changes in the regulations and shortened them by half. This Final Rule adopts most of those changes, with some significant substantive modifications and relatively few editorial and clarifying alterations.

Synopsis of Substantive Provisions

The Confidentiality of Alcohol and Drug Abuse Patient Record regulations (42 CFR Part 2) cover any program that is specialized to the extent that it holds itself out as providing and provides alcohol or drug abuse diagnosis, treatment, or referral for treatment and which is federally assisted, directly or indirectly (§ 2.12 (a) and (b)).

The regulations prohibit disclosure or use of patient records ("records" meaning any information whether recorded or not) unless permitted by the regulations (§ 2.13). They do not prohibit giving a patient access to his or her own records (§ 2.23). However, the regulations alone do not compel disclosure in any case (§ 2.3(b)).

The prohibition on disclosure applies to information obtained by the program which would identify a patient as an alcohol or drug abuser (§ 2.12(a)(1)). The restriction on use of information to investigate or to bring criminal charges against a patient applies to any alcohol or drug abuse information obtained by the program (§ 2.12(a)(2)).

Any disclosure premitted under the regulations must be limited to that information which is necessary to carry out the purpose of the disclosure (§ 2.13).

The regulations permit disclosure of information if the patient consents in writing in accordance with § 2.31. Any information disclosed with the patient's consent must be accompanied by a statement which prohibits further disclosure unless the consent expressly permits further disclosures or the redisclosure is otherwise permitted by the regulations (§ 2.32). Special rules govern disclosures with the patient's consent for the purpose of preventing multiple enrollments (§ 2.34) and for criminal justice referrals (§ 2.35).

The regulations permit disclosure without patient consent if the disclosure is to medical personnel to meet any individual's bona fide medical emergency (§ 2.51) or to qualified personnel for research (§ 2.52), audit, or program evaluation (§ 2.53). Qualified personnel may not inlcude patient identifying information in any report or otherwise disclose patient identities except back to the program which was the source of the information (§§ 2.52(b) and 2.53(d)).

The regulations permit disclosure pursuant to a court order after the court has made a finding that "good cause" exists. A court order may authorize disclosure for noncriminal purposes (§ 2.64); for the purpose of investigating or prosecuting a patient if the crime involved is extremely serious (§ 2.65); for the purpose of investigating or prosecuting a program or a person holding the records (§ 2.66); and for the purpose of placing an undercover agent or informant to criminally investigate empolvees or agents of the program (§ 2.67).

A court order may not authorize disclosure of confidential communications unless disclosure is necessary to protect against an existing threat to life or serious bodily injury of another person; to investigate or prosecute an extremely serious crime; or if the patient brings the matter up in any legal proceedings (§ 2.63).

A court order may not authorize qualified personnel who received information without patient consent for the purpose of conducting research, audit, or program evaluation, to disclose that information or to use it to conduct any criminal investigation or prosecution of a patient (§ 2.62). Information obtained under a court order to investigate or prosecute a program or other person holding the records or to place an undercover agent or informant may not be used to conduct any investigation or prosecution of a patient or as the basis for a court order to criminally investigate or prosecute a patient (§ 2.66(d)(2) and § 2.67(e)).

These regulations do not apply to the Veteran's Administration, to exchanges within the Armed Forces or between the Armed Forces and the Veterans' Administration; to the reporting under State law of incidents of suspected child abuse and neglect to appropriate State or local authorities; to communications within a program or between a program and an entity having direct administrative control over the program; to communications between a program and a qualified service organization; and to disclosures to law enforcement officers concerning a patient's commission of (or threat to commit) a crime at the program or against personnel of the program (§ 2.12(c)).

If a person is not now and never has been a patient, there is no patient record and the regulations do not apply (§ 2.13(c)(2)).

Any answer to a request for a disclosure of patient records which is not permitted must not affirmatively reveal that an identified individual has been or is an alcohol or drug patient. One way to make such an answer is to give a copy of the confidentiality regulations to the person who asked for the information along with general advice that the regulations restrict the disclosure of alcohol or drug abuse patient records and without identifying any person as an alcohol or drug abuse patient (§ 2.13(c)).

Each patient must be told about these confidentiality provisions and furnished a summary in writing (§ 2.22).

There is a criminal penalty for violating the regulations: not more than $500 for a first offense and not more than $5,000 for each subsequent offense (§ 2.4).

COMPARISON WITH PROPOSED RULE

Subpart A—Introduction

Reports of Violations

Both the existing and proposed rules provide for the reporting of any violations of the regulations to the United States Attorney for the judicial district in which the violations occur, for reporting of violations on the part of methadone programs to the Regional Offices of the Food and Drug Administration, and for reporting violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract. (See §§ 2.7 and 2.5, respectively.)

Inasmuch as it is the Department of Justice which has ultimate and sole responsibility for prosecuting violations of these regulations, the Final Rule continues to provide for the reference of reports of any violations to the United States Attorney for the judicial district in which the violations occur.

It also continues to provide for the reference to the Regional Offices of the Food and Drug Administration of any reports of violations by a methadone program. As a regulatory agency, the Food and Drug Administration has both the organization and authority to respond to alleged violations.

The Final Rule no longer directs reports of violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract or, as in the proposed revision of the rules, violations by a Federal agency to the Federal agency responsible for the program. This change is made in recognition of the lack of investigative tools available to granting and contracting agencies and of the ultimate referral which must be made to the Department of Justice. Of course, if alleged violations come to the attention of the Department of Health and Human Services, they will be forwarded to an appropriate representative of the Department of Justice.

Subpart B—General Provisions

Specialized Programs

Like the proposed rule at § 2.12, the Final Rule is applicable to any alcohol and drug abuse information obtained by a federally assisted alcohol or drug abuse program. "Program" is defined in § 2.11 as a person which says it provides and which actually provides alcohol or drug abuse diagnosis, treatment, or referral for treatment. A program may provide other services in addition to alcohol and drug abuse services, for example mental health or psychiatric services, and nevertheless be an alcohol or drug abuse program within the meaning of these regulations so long as the entity is specialized by holding itself out to the community as providing diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse.

If a facility is a provider of general medical care, it will not be viewed in whole or in part as a program unless it has either (1) an identified unit, i.e., a location that is set aside for the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment, or (2) it has personnel who are identified as providers of diagnosis, treatment, or referral for treatment *and* whose primary function is the provision of those alcohol or drug abuse services.

Regardless of whether an entire legal entity is a program or if a part of the entity is a program, the confidentiality protections cover alcohol or drug abuse patient records within any federally assisted program, as "program" is defined in these regulations.

Those comments opposed to limiting applicability of the regulations to "specialized" programs focused on the desirability of full and uniform applicability of confidentiality standards to any alcohol or drug abuse patient record irrespective of the type of facility delivering the services.

The Department takes the position that limiting applicability to specialized programs, i.e., to those programs that hold themselves out as providing and which actually provide alcohol or drug abuse diagnosis, treatment, and referral for treatment, will simplify administration of the regulations without significantly affecting the incentive to seek treatment provided by the confidentiality protections. Applicability 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. We do not foresee that elimination of hospital emergency rooms and general medical or surgical wards from coverage will act as a significant deterrent to patients seeking assistance for alcohol and drug abuse.

While some commenters suggested that there will be an increased administrative burden for organizations operating both a specialized alcohol and/or drug abuse program and providing other health services, we view this as the same burden facing all general medical care facilities under the existing rule.

In many instances it is questionable whether applicability to general medical care facilities addresses the intent of Congress to enhance treatment incentives for alcohol and drug abuse inasmuch as many alcohol and/or drug abuse patients are treated in a general medical care facility not because they have made a decision to seek alcohol and drug abuse treatment but because they have suffered a trauma or have an acute condition with a primary diagnosis of other than alcohol or drug abuse.

In sum, we are not persuaded that the existing burden on general medical care facilities is warranted by the benefit to patients in that setting. Therefore, the Final Rule retains the language of the proposed rule at § 2.11 defining "program" and making the regulations applicable at § 2.12 to any information about alcohol and/or drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program for the purpose of treating, making a diagnosis for treatment, or making a referral for treatment of alcohol or drug abuse.

Communications between a Program and an Entity Having Direct Administrative Control

The existing regulations at § 2.11(p)(1) and the proposed rule at § 2.12(c)(3) exempt from the restrictions on disclosure communications of information within a program between or among personnel in connection with their duties or in connection with provision of patient care, respectively. The Department has previously interpreted the existing provision to mean that communications within a program may include communications to an administrative entity having direct control over the program.

The Final Rule has incorporated that legal opinion into the text by amending § 2.12(C)(3) to exempt from restrictions on disclosure "communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis treatment, or referral for treatment of alcohol or drug abuse" if the communications are within a program or between a program and an entity that has direct administrative control over the program. Paragraph (d) of that same section is accordingly amended to restrict any further disclosure by an administrative entity which receives information under § 2.12(c)(3).

Explanation of Applicability

The existing regulations are applicable to patient records maintained in connection with the performance of

any alcohol abuse or drug abuse prevention function which is federally assisted. Applicability is determined by the nature and purpose of the records, not the status or primary functional capacity of the recordkeeper. The definition of "alcohol abuse or drug abuse prevention function" includes specified activities "even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs."

The proposed regulations and the Final Rule at § 2.12 make the regulations applicable to any information about alcohol and drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program. A program is defined to be those persons or legal entities which hold themselves out as providing and which actually provide diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse. Thus, there is a fundamental shift toward determining applicability on the basis of the function of the recordkeeper and away from making that decision based solely on the nature and purpose of the records.

No alcohol and drug abuse patient records, whether identified by the nature and purpose of the records or the function of the recordkeeper, are covered by these regulations unless the diagnosis, treatment, or referral for treatment with which the records are connected is federally assisted.

Several commenters pointed out that while the regulatory language of the proposed rule on its face applies the rule to information about alcohol and drug abuse patients in federally assisted programs, the explanation of the applicability provision at § 2.12(e)(2) obscures the otherwise forthright statement by an additional standard based on the type of Federal assistance going to the program, i.e., some patient records in a federally assisted program would be covered and others would not. Those who commented on this section urged that coverage distinctions under the explanation in § 2.12(e)(2) be omitted because they result in disparate treatment of patient records within an alcohol and/or drug abuse program based on the type of Federal assistance going to the program. Other commenters asserted that basing coverage on the type of assistance is inconsistent with the clear meaning of the applicability provision in the proposed and Final Rule.

The Final Rule revises the proposed explanatory material at § 2.12(e)(2) to show that all alcohol and drug abuse patient records within a covered program are protected by the confidentiality provisions and that the record of an individual patient in an uncovered program, whose care is federally supported in some way which does not constitute Federal assistance to the program under § 2.12(b), is not afforded confidentiality protections. Thus, where a Federal payment is made to a program on behalf of an individual patient and that program is not otherwise federally assisted under § 2.12(b), the record of that individual will not be covered by the regulations. Although the Department expects them to be rare, it would be possible for such instances to occur. For example, if a Federal court places an individual in a for-profit program that is not certified under the Medicare program, that is not authorized to conduct methadone treatment, and is not otherwise federally assisted in any manner provided in § 2.12(b), the patient record of that individual would not be covered by the regulations even though the Federal court paid for the individual's treatment.

Comments to the proposed rule were persuasive that the type of assistance should not affect the scope of records covered within a covered program. When the determination of covered records was based on the purpose and nature of each record, it was consistent to view Federal assistance from the perspective of each individual record. However, when the determination of which records are covered is based on who is keeping the records, as in the proposed and Final Rule, it is consistent with the approach to view Federal assistance from the program level as applying to all alcohol and drug abuse patient records within the program.

Determining coverage based on Federal assistance to the program rather than to an individual represents a change in policy from the current regulations under which the Department views a Federal payment made on behalf of an individual as sufficient to cover that individual's record. However, any disadvantage in not covering individual records in those rare cases which may occur is outweighed by the advantages of consistency and efficiency in management of the program as a result of all alcohol and drug abuse patient records in the program being subject to the same confidentiality provisions.

The Final Rule includes new material at § 2.12(e)(3) which briefly explains the types of information to which the restrictions are applicable, depending on whether a restriction is on disclosure or on use. A restriction on disclosure applies to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges or investigate a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.

Several commenters strongly urged the explicit inclusion of school-based education and prevention programs in the applicability of the regulations. School-based education and prevention activities may fall within the definition of a program if they provide alcohol or drug abuse diagnosis, treatment, or referral for treatment and if they hold themselves out as so doing. That is reflected in the Final Rule at § 2.12(e)(1) with the inclusion of "school-based programs" in the list of entities which may come under the regulations.

An example of how diagnosis affects coverage has been omitted at § 2.12(e)(3)(ii). It is omitted not because the example could never occur under the Final Rule, but because it is very unlikely that a "specialized" program, as program is defined under these regulations, would be treating a patient for a condition which is not related to alcohol or drug abuse such that the reference to a patient's alcohol or drug abuse history would not be related to the condition for which treatment is rendered. Inasmuch as the regulations only apply to programs, this example is more likely to confuse than provide guidance and for that reason has been taken out.

Notifying a Parent or Guardian of a Minor's Application for Treatment

The proposed rule at § 2.14 reorganized and revised but did not substantively amend the existing § 2.15 dealing with the subject of minor patients. Under both the existing and proposed rules, a minor patient's consent is generally required prior to notifying the minor's parent or guardian of his or her application for treatment. This is true even though without notification it is impossible to obtain parental consent in those cases where State law requires a parent, guardian, or other person to consent to alcohol or drug abuse treatment of a minor.

While this issue was not raised in the proposed rule, the Department has received several inquiries on it from the public since the proposed rule was published suggesting that in those States, where the parent's or guardian's consent is needed for the minor's treatment, the program should be free to notify the parent or guardian of the minor's application for treatment without constraint. The Department has considered this issue and decided to

make no substantive changes in the existing section dealing with minor patients.

Although both the current rule and the proposed rule generally prohibit parental notification without the minor's consent, they also provide for an exception. Under this exception such notification would be permitted when, in the program director's judgment, the minor lacks the capacity to make a rational decision on the issue of notification, the situation poses a substantial threat to the physical well-being of the minor or any other person, and this threat may be alleviated by notifying the parent or guardian. Under this provision, the program director is vested with the authority to determine when the circumstances permitting parental notification arise. In discussing the Department's philosophy behind this provision, § 2.15–1(e) of the existing rule states: "It [this provision] is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly so require."

While this exception would not permit parental notification without constraint whenever the program director feels it is appropriate, the Department believes it does provide the program director with significant discretion and does permit parental notification in the most egregious cases where the "best interests of the patient clearly so require." Accordingly, the Department has determined not to make any substantive changes in the manner in which the existing rule handles the issue of parental notification. However, proposed § 2.14 has been revised to clarify that no change in meaning is intended from the current rule.

Finally, it should be noted that this rule in no way compels a program to provide services to a minor without parental consent.

Separation of Clinical from Financial/Administrative Records

The current rules governing research, audit, or evaluation functions by a governmental agency at § 2.53 state that "programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification." The proposed rule transformed this hortatory provision for maintenance of financial/administrative records apart from clinical records into a requirement in § 2.16 dealing with security for written records.

Several commenters predicted that such a requirement will pose an extremely cumbersome burden on programs, perhaps tantamount to requiring maintenance of two systems of files. The Final Rule has adopted the recommendation of those commenters to drop this requirement, primarily on the basis of the potential administrative and recordkeeping problems it poses in the varied treatment settings to which these regulations are applicable.

While it is desirable to withhold clinical information from any research, audit, or program evaluation function for which that clinical information is not absolutely essential, the Final Rule does not require recordkeeping practices designed to guarantee that outcome. The Final Rule does, of course, implement the statutory provisions which prohibits those who receive patient identifying information for the purpose of research, audits, or program evaluation from identifying, directly or indirectly, any individual patient in any report of such research, audit, or evaluation or otherwise disclosing patient identities in any manner (see §§ 2.52(b) and 2.53(d)).

Subpart C—Disclosures with Patient's Consent

Notice to Patients

Like the proposed rule, the Final Rule at § 2.22 requires that notice be given to patients that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. The response to this provision in the proposed rule reflects strong support for notifying patients of confidentiality protections, although many stressed that the notice should be simplified in order to be useful rather than confusing to the patient. Some of those who recommended against adoption of a notice provision did so on grounds that the notice as proposed is too complex. Therefore, in response to many who supported the notice provision and those who opposed it on grounds that it is too complex, the Final Rule substantially revises the elements which must be included in the written notice to each patient and accordingly rewrites the sample notice which a program may adopt at its option in fulfillment of the notice requirement.

Form of Written Consent

The proposed rule retains the requirements in § 2.31 of the existing regulations for written consent to disclosure of information which would identify an individual as an alcohol or drug abuser. There was a great deal of support among those who commented on this provision for the retention of the existing elements of written consent on grounds that the present system is working well and that the elements which go to make up written consent are sufficiently detailed to assure an opportunity for a patient to make an informed consent to disclose patient identifying information. Others recommended a more generalized consent form.

The Final Rule retains all elements previously required for written consent, though in one instance it will permit a more general description of the required information. The first of the required elements of written consent in both the existing and proposed rule (§ 2.31 (a)(1)) asks for the name of the program which is to make the disclosure. The Final Rule will amend that element by calling for "(1) The specific name or general designation of the program or person permitted to make the disclosure." This change will permit a patient to consent to disclosure from a category of facilities or from a single specified program. For example, a patient who chooses to authorize disclosure of all his or her records without the necessity of completing multiple consent forms or individually designating each program on a single consent form would consent to disclosure from all programs in which the patient has been enrolled as an alcohol or drug abuse patient. Or, a patient might narrow the scope of his or her consent to disclosure by permitting disclosure from all programs located in a specified city, from all programs operated by a named organization, or as now, the patient might limit consent to disclosure from a single named facility. (In this connection, the Department interprets the existing written consent requirements to permit consent to disclosure of information from many programs in one consent form by listing specifically each of those programs on the form.)

This change generalizes the consent form with respect to only one element without diminishing the potential for a patient's making an informed consent to disclose patient identifying information. The patient is in position to be informed of any programs in which he or she was previously enrolled and from which he or she is willing to have information disclosed.

With regard to deficient written consents, the Final Rule at § 2.31(c) reverts to language from the existing regulations rather than using the language of the proposed rule to express the idea that a disclosure may not be made on the basis of a written consent

which does not contain all required elements in compliance with paragraph (a) of § 2.31. There was no intention in drafting the proposed rule to establish a different or more stringent standard than currently exists prohibiting disclosures without a conforming written consent. Because that was misunderstood by some, the Final Rule will not permit disclosures on the basis of a written consent which, "On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section . . ."

Express Consent to Redisclosure Permitted

Both the existing and proposed rules at § 2.32 prohibit redisclosure by a person who receives information from patient records pursuant to the written consent of the patient and who has been notified that the information is protected by Federal rules precluding redisclosure except as permitted by those Federal rules. However, the statement of the prohibition on redisclosure at § 2.32 does not make evident the Department's interpretation that it is possible for a patient, at the same time consent to disclosure is given, to consent to redisclosure in accordance with the Federal rules. The Final Rule rewords the statement of prohibition on redisclosure and adds the phrase shown in quotes below to the second sentence as follows:

> The Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the" written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

The purpose of the added phrase is to acknowledge that redisclosure of information may be expressly permitted in the patient's written consent to disclosure. For example, a patient may consent to disclose pertinent information to an employment agency and at the same time permit the employment agency to redisclose this information to potential employers, thus making unnecessary additional consent forms for redisclosures to individual employers. Similarly, a patient may consent to disclose pertient information to an insurance company for the purpose of claiming benefits, and at the same time consent to redisclosure by that insurance company to another organization or company for the purpose of administering the contract under which benefits are claimed by or on behalf of the patient.

Patient Consent to Unrestricted Communications for the Purpose of Criminal Justice System Referrals

Most of those who commented on the revision of § 2.35 generally supported the proposed changes. However, two State commenters encouraged retention of language in the existing regulations which explicitly permits a patient to consent to "unrestricted communications." Otherwise, those commenters say, the revision will act as a deterrent to criminal justice system referrals.

Both the proposed and Final Rule omit most limitations on disclosures to which a patient may consent. The criteria for permitting release of information with patient consent under the Final Rule are: (1) A valid consent under § 2.31 and (2) a determination that the information disclosed is necessary to carry out the purpose for which the consent was given (§ 2.13(a)). Although special rules for disclosures in connection with criminal justice system referrals were retained, they do not restrict "how much and what kind of information" a patient may consent to have disclosed under § 2.31. Section 2.31(a)(5) places no restrictions on how much or what kind of information a patient may consent to have disclosed. That section simply requires that each written consent describe how much and what kind of information the patient consents to have disclosed. A patient may consent to disclosure of any information concerning his or her participation in a program. In the case of a consent for the purpose of a criminal justice system referral, consent to disclose "any information concerning my participation in the program" pursuant to § 2.31(a)(5) would permit "unrestricted communications" from the program to appropriate persons within the criminal justice system to the same extent permitted by the existing rule. Therefore, the Final Rule does not substantively alter § 2.35 as proposed. (Paragraph (c) has been reworded for clarity.)

Subpart D—Disclosures Without Patient's Consent

Elimination of the Requirement to Verify Medical Personnel Status

The proposed regulations at § 2.51 implement the statutory provision which permits a disclosure "to medical personnel to the extent necessary to meet a bona fide medical emergency." The proposed rule added a requirement not contained in the existing § 2.51 that the program make a reasonable effort to verify that the recipient of the information is indeed medical personnel.

The Final Rule deletes the proposed verification requirement in response to comments from several sources that such a requirement is unnecessary, will cause delay, and could possibly impede emergency treatment. In view of those comments and our interest in easing the burden of compliance where possible, the Final Rule does not require verification of the "medical personnel" status of the recipient of information in the face of a medical emergency.

However, the statute permits disclosures only to medical personnel to meet a medical emergency and elimination of the verification requirement does not in any way expand upon the category of persons to whom a disclosure may be made to meet a medical emergency. Neither does elimination of the verification requirement affect the provision in the Final Rule at § 2.51(c) that a program document in the patient's records any disclosure which is made in the face of a medical emergency.

Assessment of Research Risks

The proposed regulations at § 2.52 modified and streamlined existing provisions in §§ 2.52 and 2.53 governing disclosures for scientific research. The proposal clarified that the determination of whether an individual is qualified to conduct scientific research would be left to the program director, and required that such qualified personnel have a research protocol which includes safeguards for storing patient identifying information and prohibits redisclosures except as allowed by these regulations.

The Final Rule adds an additional condition: The program director must ensure that a written statement is furnished by the researcher that the research protocol has been reviewed by an independent group of three or more individuals who found that the rights of patients would be adequately protected and that the potential benefits of the research outweigh any potential risks to patient confidentiality posed by the disclosure of records.

This revision was prompted by comment from both the public and private sectors that review of the research protocol for the purpose of ensuring the protection of human subjects participating in the research (in this case, the patients whose records are proposed for use in research) is imperative prior to permitting disclosure of patient identifying information for the conduct of scientific research. The requirement that researchers state in writing that the protocol has been reviewed for the protection of human subjects will provide an additional point

of reference for the program director in determining whether to release patient identifying information for research purposes.

Researchers who receive support from the Department and many other Federal agencies are required under regulations for the protection of human subjects to obtain review of their protocol from an "institutional review board (IRB)." Such boards generally are set up by the institution employing the researcher. Regulations require that IRBs be composed of persons with professional competence to review research, as well as persons who can judge sensitivity to community attitudes and ethical concerns. Documentation of review and approval by an IRB or by another group of at least three individuals, appropriately constituted to make judgements on issues concerning the protection of human subjects, would meet the new requirement in § 2.52(a)(3).

Audit and Evaluation Activities by Nongovernmental Entities

The proposed regulations at § 2.53 simplify and shorten the provisions on audit and evaluation activities and divide them into two categories: (1) Those activities that do not require copying or removal of patient records, and (2) those that require copying or removal of patient records. The proposed rule permits governmental agencies to conduct audit and evaluation activities in both categories. In addition, if no copying or removal of the records is involved, the program director may determine that other persons are "qualified personnel" for the purpose of conducting audit and evaluation activities. There is no provision for nongovernmental entities to perform any audit or evaluation activity if copying or removal of records is involved.

In response to the proposed rule the Department received comment that third party payers should be permitted to copy or remove records containing patient identifying information as is permitted by governmental agencies that finance or regulate alcohol or drug abuse programs.

Recognizing that private organizations, like governmental agencies, have a stake in the financial and programmatic integrity of treatment programs arising out of their financing of alcohol and drug abuse programs directly, out of peer review responsibilities, and as third party payers, the Final Rule permits access to patient identifying information for audit and evaluation activities by private organizations in circumstances identical to the access afforded governmental agencies. Specifically, if a private organization provides financial assistance to a program, is a third party payer covering patients in the program, or is a peer review organization performing a utilization or quality control review, the Final Rule permits the private organization to have access to patient identifying information for the purpose of participating in audit and evaluation activities to the same extent and under the same conditions as a governmental agency.

Audit and Evaluation of Medicare or Medicaid Programs

In response to specific questions which have come to the Department's attention and in recognition of the continued importance of the integrity of the Medicare and Medicaid programs to the delivery of alcohol and drug abuse services, the Final Rule includes a new paragraph (c) in § 2.53 which clarifies the audit and evaluation provisions as they pertain to Medicare or Medicaid.

Specifically, the new paragraph clarifies that the audit and evaluation function includes investigation for the purpose of administrative enforcement of any remedy imposed by law by any Federal, State, or local agency which has responsibility for oversight of the Medicare or Medicaid programs. The new paragraph makes explicit that the term "program" includes employees of or providers of medical services under an alcohol or drug abuse program. Finally, it clarifies that a peer review organization may communicate patient identifying information for the purpose of a Medicare or Medicaid audit or evaluation to the agency responsible for oversight of the Medicare or Medicaid program being evaluated or audited.

Subpart E—Court Orders Authorizing Disclosure and Use

Court-Ordered Disclosure of Confidential Communications

The existing regulations at § 2.63 limit a court order to "objective" data and prohibit court-ordered disclosure of "communications by a patient to personnel of the program." The proposed regulations delete the provision restricting a court order to objective data and precluding an order from reaching "communications by a patient to personnel of the program." Deletion of that provision provoked considerable discussion and concern on the part of a large number of persons, 85% of whom opposed allowing court-ordered disclosure of nonobjective data.

The Final Rule at § 2.63 restores protection for many "communications by a patient to personnel of the program" and information which is of a nonobjective nature, but it does not protect that information from court order in the face of an existing threat to a third party or in connection with an investigation or prosecution of an extremely serious crime.

Because the existing regulations seem to be dealing uniformly with two related but not necessarily identical types of information, i.e., "objective" data and "communications by a patient to personnel of the program," the Final Rule drops those terms in favor of the term "confidential communications," a term in use since 1975 in existing § 2.63–1. "Confidential communications" are the essence of those matters to be afforded protection and are as readily identified as "objective" data. Furthermore, protection of "confidential communications" is more relevant to maintaining patient trust in a program than is protection of "communications by a patient to personnel of the program," a term which does not distinguish between the innocuous and the highly sensitive communication.

Most comments in opposition to relaxing the court order limitations on confidential communications said that the potential for court-ordered disclosure of confidential communications will compromise the therapeutic environment, may deter some alcohol and drug abusers from entering treatment, and will yield information which may be readily misinterpreted or abused.

While freedom to be absolutely candid in communicating with an alcohol or drug abuse program may have therapeutic benefits and may be an incentive to treatment, it is the position of the Department that those therapeutic benefits cannot take precedence over two circumstances which merit court-ordered disclosure of confidential communications.

The first of these is a circumstance in which the patient poses a threat to any third party. Existing rules do not permit a court to authorize disclosure of any communication by a patient to a program; for example, that the patient is abusing a child or has expressed an intention to kill or seriously harm another person. The balance between patient confidentiality and an existing threat posed by the patient to life or of serious bodily injury to another person must be weighted in favor of permitting a court to order disclosure of confidential communications which are necessary to protect against such an existing threat.

The second of these circumstance is one in which a patient's confidential

communications to a program are necessary in connection with investigation or prosecution of an extremely serious crime, such as a crime which directly threatens loss of life or serious bodily injury. The Department takes the position that it is consistent with the intent of Congress and in the best interest of the Nation to permit the exercise of discretion by a court, within the context of the confidentiality law and regulations, to determine whether to authorize disclosure or use of confidential communications from a patient's treatment record in connection with such an investigation or prosecution.

Our aim is to strike a balance between absolute confidentiality for "confidential communications" on one side and on the other, to protect against any existing threat to life or serious bodily harm to others and to bring to justice those being investigated or prosecuted for an extremely serious crime who may have inflicted such harm in the past. While many confidential communications will remain beyond the reach of a court order, revised § 2.63 of the Final Rule will permit a court to authorize disclosure of confidential communications if the disclosure is neccessary to protect against an existing threat to life or serious bodily injury, if disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, or, as in the existing rule, if disclosure is in connection with a legal proceeding in which the patient himself/herself offers testimony or evidence concerning the confidential communications.

Open Hearing on Patient Request in Connection with a Court Order

Courts authorizing disclosure for noncriminal purposes are required at § 2.64(c) of the Final Rule to conduct any oral argument, review of evidence, or hearing in the judge's chambers or in some manner that ensures patient identifying information is not disclosed to anyone who is not a party to the proceeding, to a party holding the record, or to the patient. The existing rules provide that a patient may request an open hearing. The proposed rule did not provide for the patient to request an open hearing.

The existing and proposed rule provides that a patient may consent to use of his or her name rather than a fictitious name in any application for an order authorizing disclosure for noncriminal purposes. The existing rule requires "voluntary and intelligent" consent. The proposed rule ensures the quality of the consent by requiring that it be in writing and in compliance with § 2.31.

Upon reconsideration, the Department has reinstated the provision permitting a patient to consent to an open hearing in a noncriminal proceeding but with the same formality as is required by the proposed rule for a consent by the patient to use his or her name in an application for an order. Therefore, the Final Rule at § 2.64(c) requires that any hearing be held in such a way as to maintain the patient's confidentiality "unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations."

Content of Court Order—Sealing of Record as an Example

The content of a court order authorizing disclosure for noncriminal purposes and any order for disclosure and use to investigate or prosecute a program or the person holding the records is limited at § 2.64(e) to essential information and limits disclosure to those persons who have a need for the information. In addition, the court is required to take such other measures as are necessary to limit disclosure to protect the patient, the physician-patient relationship, and the treatment services. We have included at § 2.64(e)(3) an example of one such measure which may be necessary: sealing the record of any proceeding for which disclosure of a patient's records has been ordered. It is the Department's experience that heightened awareness of this possibility by members of the treatment community and legal profession can limit dissemination of patient identifying information to those for whom the court determined "good cause" exists without turning all or a part of a patient's treatment record into public information. The Final Rule adds as an example of a measure which the court might take to protect the patient, the physician-patient relationship and the treatment service "sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered." A similar change has also been made in § 2.67(d)(4).

Extremely Serious Crime as a Criterion for a Court Order to Investigate or Prosecute a Patient

The proposed rule at § 2.64 purported to retain the existing standard with regard to court orders which may be issued for the purpose of investigating or prosecuting a patient; i.e., the standard that no court order may authorize disclosure and use of patient records for investigation or prosecution of nonserious crimes. In an effort to clarify the nature of those crimes for which a court may order disclosure and use of patient records to investigate or prosecute the patient, the proposed rule dropped the term "extremely serious" crime in favor of a more specific functional definition of a crime which "causes or directly threatens loss of life or serious bodily injury." While the proposed rule purported to retain the existing standard, comments received from law enforcement agencies have contested that outcome, asserting that the criterion as proposed would be significantly narrowed. Arguing in favor of a broader standard, law enforcement interests advocated a more flexible criterion which would permit courts to weigh relevant factors on a case-by-case basis.

Inasmuch as the change in the proposed rule was intended to clarify—not to further limit—those crimes for which a court may authorize use of a patient's record to investigate or prosecute the patient, the Final Rule reinstates the existing language, "extremely serious." This broader criterion will permit more flexibility and discretion by the courts in deciding whether a crime is of a caliber which merits use of a patient's treatment record to investigate or prosecute the patient.

The Final Rule names as examples of "extremely serious" crimes homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect. Deleted from the list of proposed examples is "sale of illicit drugs."

Based on the view that most patients in drug abuse treatment are vulnerable to a charge of sale of illicit drugs, many commenters asked that "sale of illicit drugs" not be categorically named as an extremely serious crime. To do so, they asserted, would make almost all patients in drug rehabilitation or treatment programs vulnerable to investigation or prosecution by means of court-ordered use of their own treatment records.

While the Final Rule eliminates "sale of illicit drugs" as an example of an extremely serious crime, it does not alter the authority of a court to find that under appropriate circumstances sale of an illicit drug is, in fact, an extremely serious crime, and it reflects a decision to leave any such determination up to a court of competent jurisdiction which is called upon to order the use of a patient's treatment records to prosecute the patient in view of any circumstances known to the court.

New Law To Permit Reporting of Child Abuse and Neglect

Section 108 of Pub. L. 99–401, the Children's Justice and Assistance Act of 1986, amends sections 523(e) and 527(e) of the Public Health Service Act (42 U.S.C. 290dd–3(e) and 42 U.S.C. 290ee–3(e)) to permit the reporting of suspected child abuse and neglect to appropriate State or local authorities in accordance with State law. The amended sections of the Public Health Service Act provide:

> The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

This newly enacted statutory exception to the restrictions on disclosure of information which would identify an alcohol or drug abuse patient provides a straightforward avenue for making reports of incidents of suspected child abuse and neglect in accordance with State law without resort to devices explained in the preamble to the proposed rule, i.e., obtaining a court order, reporting without identifying the patient as an alcohol or drug abuser, getting the patient's written consent, entering into a qualified service organization agreement, or reporting a medical emergency to medical personnel. While the potential still exists for using the devices described in the proposed rule, there is no foreseeable reason to use them to report suspected child abuse and neglect in view of the amendment.

Although the new law excepts reports of suspected child abuse and neglect from the statutory restrictions on disclosure and use, it does not affect the applicability of the restrictions to the original alcohol and drug abuse patient record maintained by the program. Accordingly, if, following a report of suspected child abuse or neglect, the appropriate State authorities wish to subpoena patient records (or program personnel to testify about patient records) for civil or criminal proceedings relating to the child abuse or neglect, appropriate authorization would be required under the statutes and regulations. While written patient consent would suffice for a civil proceeding, it would be necessary to obtain an authorizing court order under paragraph (b)(2)(C) of the confidentiality statutes and § 2.65 of the regulations for use of the record to criminally investigate or prosecute a patient.

Editorial Changes

The Final Rule makes very few editorial or clarifying changes to the regulations as proposed.

Number, tense, punctuation, and sequential numbering are changed where appropriate. Definitions applicable only to prevention of multiple enrollments in detoxification and maintenance treatment programs are moved from the definitions section to § 2.34. Section 2.35(c) has been rewritten for clarity. A clarifying phrase or word is added to the definition of "patient identifying information" at § 2.11, to § 2.19 (a)(1) and (b)(1) and to § 2.31(a)(8). The phrase "or other" has been added to § 2.53(c) because a court order under § 2.66 may be issued to investigate a program for criminal or administrative purposes. At § 2.65(d)(3) alternative language is adopted consistent with language used elsewhere to express a similar thought. At § 2.65 (d)(4) the term "program" is used in lieu of "person holding the records" inasmuch as none but a program will be providing services to patients.

Regulatory Procedures

Executive Order 12291

This is not a major rule under Executive Order 12291. Overall costs to general medical care facilities will be reduced as a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs. Cost to covered programs will be reduced somewhat by simplification of the rules. The amendments do not have an annual effect on the economy of $100 million or more or otherwise meet the criteria for a major rule under the Executive Order. Thus, no regulatory analysis is required.

Regulatory Flexibility Act

As a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs, the Final Rule will not have a significant economic impact on a substantial number of small entities. The regulations will no longer apply to general medical care providers which render alcohol or drug abuse services incident to their general medical care functions; thus, the number of small entities affected will be less than substantial. The economic impact will be less than significant because much of that impact arises from the cost of determining that the records of a general medical care patient are subject to the regulations and thereafter treating those records differently than all others in the general medical care facility. It is anticipated that programs covered by these rules will realize a small savings as a result of the simplification of the rules.

Information Collection Requirements

Information collection requirements in this Final Rule are:

(1) Obtaining written patient consent (§ 2.31(a)),

(2) Notifying each patient of confidentiality provisions (§ 2.22), and

(3) Documenting any disclosure to meet a medical emergency (§ 2.51).

The information collection requirements contained in these final regulations have been approved by the Office of Management and Budget under section 3504(h) of the Paperwork Reduction Act of 1980 and have been assigned control number 0930–0099, approved for use through April 30, 1989.

List of Subjects in 42 CFR Part 2

Alcohol abuse, Alcoholism, Confidentiality, Drug abuse, Health records, Privacy.

Dated: July 3, 1986.

Robert E. Windom,

Assistant Secretary for Health.

Approved: April 9, 1987.

Otis R. Bowen,

Secretary.

The amendments to 42 CFR Part 2 are hereby adopted as revised and set forth below:

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Subpart A—Introduction

Sec.

Subpart B—General Provisions

Authority: Sec. 408 of Pub. L. 92–255, 86 Stat. 79, as amended by sec. 303 (a), (b) of Pub. L. 93–282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94–237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94–581, 90 Stat. 2852; sec. 509 of Pub. L. 96–88, 93 Stat. 695; sec. 973(d) of Pub. L. 97–35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service Act by sec. 2(b)(16)(B) of Pub. L. 98–24, 97 Stat. 182 and as amended by sec. 106 of Pub. L. 99–401, 100 Stat. 907 (42 U.S.C. 290ee–3), and sec. 333 of Pub. L. 91–616, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93–282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94–581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98–24, 97 Stat. 181 and as amended by sec. 106 of Pub. L. 99–401, 100 Stat. 907 (42 U.S.C. 290dd–3).

Subpart A—Introduction

§ 2.1 Statutory authority for confidentiality of drug abuse patient records.

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98–24 to section 527 of the Public Health Service Act which is codified at 42 U.S.C. 290ee–3. The amended statutory authority is set forth below:

Section 290ee–3. Confidentiality of patient records.

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94–581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

§ 2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98–24 to section 523 of the Public Health Service Act

which is codified at 42 U.S.C. 290dd–3. The amended statutory authority is set forth below:

Section 290dd–3. Confidentiality of patient records

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

(g) Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection(b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94–581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

§ 2.3 Purpose and effect.

(a) *Purpose.* Under the statutory provisions quoted in §§ 2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in Subpart B (definitions applicable to § 2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in Subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in Subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in Subpart E.

(b) *Effect.* (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee–3(f), 42 U.S.C. 290dd–3(f) and 42 CFR § 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers* v. *United States*, 327 U.S. 614, 621–22, 66 S. Ct. 705, 707–08 (1946)).

§ 2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee–3(f) and 42 U.S.C. 290dd–3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

§ 2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

Subpart B—General Provisions

§ 2.11 Definitions.

For purposes of these regulations:

Alcohol abuse means the use of an alcoholic beverage which impairs the

physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means 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.

Disclose or disclosure means a communication of patient indentifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official: and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means a person which in whole or in part holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment. For a general medical care facility or any part thereof to be a program, it must have:

(a) An identified unit which provides alcohol or drug abuse diagnosis, treatment, or referral for treatment or

(b) Medical personnel or other staff whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers.

Program director means:

(a) In the case of a program which is an individual, that individual:

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.

Qualified service organization means a person which:

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

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the progams, it is fully bound by these regulations; and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment 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.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

§ 2.12 Applicability.

(a) *General—(1) Restrictions on disclosure.* The restrictions on disclosure in these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee–3(c), 42 U.S.C. 290dd–3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program;

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government until which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions*—(1) *Veterans' Administration.* These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administraton provisions of hospital care, nursing home care, domiciliary care, and medical services under Title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces.* These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans.

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

(i) within a program or

(ii) between a program and an entity that has direct administrative control over the program.

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

(5) *Crimes on program premises or against program personnel.* The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* 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.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information.* The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see § 2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—Third party payers, administrative entities, and others.* The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under § 2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on redisclosure of the records in accordance with § 2.32 of these regulations.

(e) *Explanation of applicability*—(1) *Coverage.* These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms "patient" and "program" are defined in § 2.11) if the program is federally assisted in any manner described in § 2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment.

(2) *Federal assistance to program required.* If a patient's alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under § 2.12(b), that patient's record is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in § 2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by § 2.12(b).

(3) *Information to which restrictions are applicable.* Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a

patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under § 2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover 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. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

(i) diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§ 2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients; Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with Subpart E of these regulations. The regulations permit acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicy identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

§ 2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with Subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under Subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

§ 2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors—(1) Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under Subpart C of these regulations for the sole purpose

of obtaining payment for services from a third party payer.

(b) *Deceased patients*—(1) *Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

§ 2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

§ 2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under § 2.6 of these regulations, no program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is place in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§ 2.18 Restrictions on the use of identification cards.

No person may require any patient to carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

§ 2.19 Disposition of records by discontinued programs.

(a) *General.* If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law.* If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]"; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

§ 2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee–3 and 42 U.S.C. 290dd–3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

§ 2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR Part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These "research privilege" statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under Subpart E of these regulations of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilage granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any imformation which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with Subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain information about its patients, that program may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

§ 2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required.* At the time of admission or as soon threreafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and

(2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary.* The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or

against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

(1) The patient consents in writing;

(2) The disclosure is allowed by a court order; or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd–3 and 42 U.S.C. 290ee–3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

(Approved by the Office of Management and Budget under Control No. 0930–0099.)

§ 2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

Subpart C—Disclosures With Patient's Consent

§ 2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) ☐ Request ☐ Authorize:
2. (name or general designation of program which is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name or title of the person or organization to which disclosure is to be made)

5. For (purpose of the disclosure)

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. Signature of person authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under Control No. 0930–0099.)

§ 2.32 Prohibition on redisclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by the following written statement:

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

§ 2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of § 2.34 and 2.35, respectively.

§ 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member progams patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

(i) The patient is accepted for treatment:

(ii) The type or dosage of the drug is changed: or

(iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

(i) Patient identifying information:

(ii) Type and dosage of the drug; and

(iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of § 2.31, except that:

(i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made: and

(ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not redisclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under Subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program: and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

§ 2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment:

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur: and

(3) Such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

(Approved by the Office of Management and Budget under Control No. 0930-0099.)

§ 2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research; and

(2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of § 2.16 of these regulations (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

§ 2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 2.16 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.* (1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in § 2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a peer review organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66 of these regulations.

Subpart E—Court Orders Authorizing Disclosure And Use

§ 2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records: a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restricitons of these regulations.

§ 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information

or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§ 2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order.

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§ 2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been

represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment on only that public interest and need found by the court.

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65 of these regulations.

§ 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under § 2.65 of these regulations.

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POST-TEST

TASC CRITICAL ELEMENT TRAINING POST-TEST

1. Name two types of frequently used urinalysis confirmation tests

_____

_____

2. List the three client eligibility criteria generic to most TASC programs.

_____

_____

_____

3. The best metaphor to describe TASC's linkage with criminal justice and treatment is

_____

4. List five of the ten TASC critical program elements.

_____

_____

_____

_____

_____

5. Five of the critical elements may be described as _____, while the other five are described as

_____

6. List 8 common stages in the processing of defendants by the criminal justice system.

_____ _____

_____ _____

_____ _____

_____ _____

7. Two benefits of TASC intervention to the criminal justice system include_____ and _____

8. Formal agreements between TASC and justice agencies should include _____and_____

9. List three major drug abuse treatment program modalities

_____

_____

_____

10. List two barriers to good working relationships between TASC and treatment.

_____

11. List two variables which can effect the development of local eligibility criteria

_____

_____

12. List three components of a TASC screening interview.

_____

_____

_____

13. List six components of an assessment interview.

_____ _____

_____ _____

_____ _____

TASC CRITICAL ELEMENT TRAINING PRETEST

14. List three variables which effect TASC's treatment referral capability

_____

_____

_____

15. Define the term "case management"

_____

_____

_____

_____

16. Describe the most common TASC strategy for assisting clients who are in danger of termination from a treatment program_____

_____

_____

17. List four documents which must be in the client file.

_____ _____

_____ _____

18. Define the term "chain of custody" as it relates to TASC

_____

_____

_____

_____

19. List two types of technology available for urine testing

_____

_____

20. List two differences between a general release of confidential information and a criminal justice release. _____

_____

21. List two situations where information can be released about a client without his/her consent

_____

_____

22. List five of the nine elements of a general release of information

_____

_____

_____

_____

_____

23. Where are confidentiality regulations published?_____

_____

24. List three populations other than adult drug abusers where the TASC model has been proven effective.

_____

_____

_____

25. List two problems associated with urine collection

_____

_____

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