125211

U.S. Department Of Justice
Federal Bureau of Investigation

Employee Assistance Program

December 2, 1988

Table of Contents

I. Definitions

For purposes of this program, the following terms are defined as follows:

A. Alcoholism/Alcohol Abuse - A treatable disorder/disease characterized by repeated episodes of excessive drinking which interferes with an employee's health, social adjustment and work performance.

B. Community Resources - Agencies and individual practitioners available to provide professional services to FBI employees referred to them by the Employee Assistance Program (EAP). These agencies and individual practitioners include but are not limited to: hospitals and other inpatient treatment facilities, mental health clinics, counseling centers, marriage counselors, psychologists, social workers, psychiatrists, financial counseling services and attorneys.

C. Drug Abuse - A treatable disorder/health problem characterized by a pattern of repeated episodes of drug use which interferes with an employee's health, social adjustment and work performance.

D. Drug Deterrence Program (DDP) - A comprehensive program, within the FBI, which is consistent with the President's Drug-Free Federal Workplace initiative, consisting of: urinalysis testing for drugs of abuse, referral to the EAP for counseling and rehabilitation, employee education and supervisory training about drug abuse issues.

E. Emotional/Behavioral/Mental Health Problem - A wide range of personal problems either of which may be characterized by feelings of distress and/or impairment of an employee's health, social adjustment, work performance and psychological well-being.

F. Illegal Drug - A controlled substance as defined by section 802(a) of the Controlled Substances Act, Title 21, United States Code (U.S.C.), the possession of which is unlawful.This does not include the use of a controlled substance pursuant to a valid prescription or other uses authorized by law.

G. Management Official - An employee required or authorized by the FBI to formulate, determine, interpret, or influence the policies of the FBI.

H. Supervisor - An employee required or authorized by the FBI to direct or assign work to other employees and who, through observation and the exercise of independent judgement, is able to evaluate their performance.

I. Employee Assistance Counseling - Confidential counseling by FBI Headquarters EAP staff, Field Coordinators, or other duly authorized individuals, which may include, but is not limited to, basic short-term counseling and referral services for employees with personal problems that adversely affect their work performance.

J. Self-Referral - The voluntary request for confidential EAP assistance by an employee who is, or has a family member who is experiencing a life problem which may have a negative impact on their job performance.

K. Supervisory Referral - The referral of an employee to the EAP by a supervisor as a result of recognized deteriorating job performance or conduct problem.

II. Background

Public Law 91-616, Title 42, U.S.C., Section 4551, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Public Law 92-255, Title 21, U.S.C., Section 1180, the Drug Abuse Office and Treatment Act of 1972, require Federal agencies to develop and maintain appropriate prevention, treatment and rehabilitation programs and services for Federal civilian employees with alcohol or drug abuse problems. Public Law 93-282, Title 45, U.S.C., Section 4551, enacted 5/14/74, amended both acts and brings the confidentiality requirements of each into conformity with the other. On 7/1/75, the Department of Health, Education and Welfare (now the Department of Health and Human Services) issued regulations implementing the confidentiality provisions of Public Law 93-282, Title 42, Code of Federal Regulations (CFR), Part 2, as amended 6/9/87 (Appendix D herein).

The Office of Personnel Management's (OPM) policies and guidelines for employee substance abuse programs are contained in the Federal Personnel Manual (FPM), Subchapter 792-5, FPM Supplement 792-2, and FPM Letters 792-8, dated 8/25/77, 792-10, dated 5/7/80, and 792-11, dated 5/8/80. Guidelines for broader Employee Counseling Services Programs are contained in FPM Letters 792-9, dated 5/23/79, and 792-12, dated 5/20/80. This guidance from OPM permits agencies to integrate their alcoholism and drug abuse programs into a broader system dealing with a wide range of medical, behavioral and emotional problems which can adversely affect work performance. In 1979, Public Laws 96-180 and 96-181 amended Public Laws 91-616 and 92-255 respectively. These amendments expanded coverage even further and authorized agencies to extend, to the extent feasible, alcohol and drug program services to the families of employees with alcohol and drug abuse problems, and to the employees' family member(s) with alcohol and drug problems.

In 1981, the FBI implemented a Bureau-wide alcoholism program. The purpose of this program is to motivate employees in need of assistance to accept early counseling in order to assist them in regaining their productivity; to minimize absenteeism, sick leave and grievances; to reduce the need for disciplinary action; and to improve employee morale. The Alcoholism Program is detailed in the Manual of Administrative Operations and Procedures (MAOP), Part 1, Section 15-3, "Alcoholism or Alcohol Abuse - Prevention, Treatment and Rehabilitation." This MAOP section notified employees of the establishment of the field office position of Alcoholism Program Coordinator (APC). The MAOP details the APC's responsibilities, notifies employees of the means by which they can avail themselves of APC counseling and details the confidential nature of employee alcohol abuse information and records.

Executive Order (EO) 12564, (Appendix A herein), captioned, "Drug-Free Federal Workplace," was signed by the President on 9/15/86 and requires the head of each executive agency to develop a plan for achieving a drug-free workplace. The EO mandates employee drug abuse education, supervisory training and the use of EAPs to assist those using or abusing drugs. On 10/27/86, Public Law 99-570, the Comprehensive Drug Abuse and Treatment Act of 1986, Title 21, U.S.C., Section 801 Note, was signed and reiterated congressional concern about the prevention of illegal drug use and the treatment of Federal employees who use drugs. OPM addressed EAP legal issues in FPM Letter 792-16, dated 11/28/86, and 792-17, dated 3/9/87 (Appendix B and C herein). FPM Letter 792-16 made clear that EO 12564 requires the FBI to maintain an EAP.

III. Purpose

The purpose of the EAP, within the FBI, is to provide basic, short-term counseling and referral services to all employees with personal problems that adversely affect their work performance. This program is in keeping with efforts by the Federal government to eliminate illegal drug use by its employees and to offer an opportunity for those affected to seek rehabilitative assistance. The present EAP has evolved from the Alcoholism Program and represents an expansion of coverage to include not only alcoholism and alcohol abuse but also drug abuse and a broad range of medical and behavioral problems, to include medical, emotional, financial, marital and other family difficulties.

IV. Objective

The FBI recognizes that alcohol, drug and other personal problems of its employees can and do adversely affect job performance at all levels of responsibility. Our employees have always been our most valuable resource and their welfare and the overall welfare of the organization are viewed as synonymous. When employee problems go unaddressed or are handled inappropriately, the loss to the FBI in terms of economic and human suffering, is incalculable.

Studies estimate that as much as five percent of our nation's adults suffer from alcoholism, another two percent from drug abuse, and thirteen percent from a variety of other emotional/behavioral problems. This suggests that approximately twenty percent of the work force can be characterized as preoccupied with personal problems and significantly less productive than the average worker. Furthermore, these employees account for an inordinate amount of absenteeism, tardiness, accidents (automobile and others), administrative inquiries, disciplinary actions, health care benefit utilization, security violations, resignations, dismissals, early retirements and conflicts with co-workers. The overall impact on the

organization is impaired efficiency, unfavorable public relations and lowered morale.

Bureau employees have a right to a safe and secure workplace, and all American citizens, who depend on the FBI for their safety and security, have a rightful expectation to a reliable and efficient delivery of law enforcement services. Because of our unique responsibilities as an investigative organization, there can be no relaxation of FBI standards of conduct. FBI policy continues to rest on MAOP, Part I, Section 1-2, which states, in part, that "employees should never cause themselves to be mentally or physically unfit for duty." In addition, the use of illegal drugs by FBI employees, whether on or off the job, cannot be tolerated.

The objective of the EAP is to reaffirm the FBI's commitment to the welfare of its employees while maintaining its standards of conduct and dedication to the accomplishment of its missions. It is not the purpose of this program to unnecessarily interfere in any manner with an employee's private life or to attempt to influence his or her personal decisions away from the workplace. However, the FBI is concerned with its employees' personal behavior and decision making, when their actions interfere with the efficient and safe performance of assigned duties, discredit the reputation of the organization, or adversely affect other employees. The EAP is a supervisory alternative/supplement and emphasizes the offering of rehabilitative help to employees through referral to appropriate community resources. It is not a disciplinary program, nor conversely, a haven for problem employees, and it does not replace existing disciplinary policies and practices.

V. Statement Of Policy

It is the policy of the FBI to provide confidential, short-term counseling and referral assistance to employees who have personal problems that adversely affect their job performance and health. Ordinarily, an employee will overcome personal life problems independently and there may be little or no effect on job performance. If the employee cannot resolve such problems alone, traditional supervisory practices may serve as the needed motivation or guidance necessary to return the employee's job performance to an acceptable level. In some cases, however, neither the efforts of the employee nor the supervisor are effective at resolving the employee's problems and unsatisfactory job performance persists. The EAP will be available to deal with such persistent employee problems within the following framework:

A. The FBI recognizes that almost any human problem is treatable if identified early and provided referral is made to the appropriate community resource for care. These problems include but are not limited to: alcoholism, drug abuse, physical illness, mental or emotional distress, marital and family

problems, financial and legal concerns.

B. For the purposes of this policy, alcoholism is a preventable and treatable disease in which the employee's job performance can be impaired as a direct consequence of the abuse of alcohol.

C. With regard to drug abuse, the FBI recognizes that this is a treatable health problem and employees with this problem will receive the same offer of assistance as that extended to employees having any other illness or health problem. However, the Bureau cannot condone employee drug activity which is contrary to law. When illegal drug use is involved, an individual's participation in the EAP will not preclude the Bureau from taking appropriate disciplinary/administrative action against the employee for his or her use of illegal drugs, except as provided herein for voluntary referrals. Disciplinary action in accordance with EO 12564 can be initiated and could include the full range of disciplinary/administrative actions up to and including dismissal.

D. When supervisors have good reason to believe that an employee's problem also involves criminal conduct directed toward or potentially harmful to the person or property of others, this information should be reported to the appropriate authority in accordance with existing policy set out in the MAOP, Part I, Section 1-4, entitled, "Illegal Activities" and Part I, Section 13, entitled, "Disciplinary Matters."

E. The EAP is not bound to extend assistance to an individual who persists in conduct that is contrary to law, openly discusses illegal activities, or plans or exhibits behavior that would threaten either their own life or the lives of others.

F. Employees will not have their job security, promotion opportunities or retirement eligibility jeopardized on account of their request for referral assistance and participation in the EAP.

G. Employees found to be using illegal drugs as a result of urinalysis drug testing pursuant to the FBI's DDP, or who have otherwise been identified by management officials to be using illegal drugs, shall be referred to the EAP. An employee's decision to participate in the EAP when he or she has been referred under these circumstances will be taken into consideration by management officials and disciplinary/administrative action will be decided on a case-by-case basis depending on all mitigating factors and the totality of the circumstances. Such considerations will include, but is not limited to, the sensitivity of the employee's position and whether the employee's conduct has undermined the Bureau's confidence in his/her trustworthiness. The intent of the EAP policy is rehabilitative and not punitive. Management will make

a reasonable effort to retain those employees who voluntarily seek EAP assistance, even for drug abuse, and to restore them to full productivity.

H. Information concerning individuals who participate in the EAP is confidential and governed by Federal regulations which impose criminal penalties for improper disclosure. Records and EAP counselor's notes pertaining to an individual's participation in this program are privileged and will not be referred to or made a part of an employee's Official Personnel Folder. The confidentiality of these records/information, whether recorded or not, will be maintained in accordance with: Title 42, CFR, Part 2 (Appendix D herein), the Privacy Act, Title 5, U.S.C., Section 552a (1984), and all other relevant laws and regulations.

I. Employees who decide to undergo a prescribed program of treatment or rehabilitation which will require absence from work will be granted sick leave as is the case with any other health problem. If the individual has an insufficient amount of accrued sick leave available, advanced sick leave, annual leave, or leave-without-pay shall be granted for this purpose in accordance with the Leave/Time and Attendance (T & A) Manual. Administrative leave should be allowed when an employee meets with an EAP Coordinator.

VI. Program Administration

A. Director

The Director is responsible for establishing the EAP within the FBI in accordance with the authorities and legislative guidance described herein. In this regard, he has delegated to the Assistant Director, Administrative Services Division the overall responsibility for administrative oversight and management of the EAP.

B. Assistant Director, Administrative Services Division (ASD)

The Assistant Director, ASD, is responsible for:

1) Providing guidance and support concerning policy development and interpretation, procedural direction and evaluation of the EAP; and

2) The administrative oversight of the Personnel Section and supervision of the Personnel Officer.

C. Personnel Officer

The Personnel Officer is responsible for:

1) Program development, implementation and the allocation of personnel resources consistent with program manpower needs, the needs of the organization and current personnel regulations;

2) The administration of the Personnel Section which includes direct administrative control of the Health Care Programs Unit;

3) Designating an EAP Administrator (EAA) to provide for the implementation of the EAP;

4) Ensuring, through appropriate training and orientation, that all FBI supervisory and management personnel are aware of this policy and their individual responsibilities within the program;

5) Ensuring that all individuals performing an EAP function are provided with training and educational opportunities consistent with the effective delivery of services and the needs of the organization;

6) Providing training/familiarization for all EAP personnel in matters pertaining to individual confidentiality and allowing those individuals, within the scope of their employment, to perform their EAP duties in accordance with the provisions of Federal confidentiality regulations and law; and

7) Publicizing the EAP's services to all FBI employees.

D. Chief, Health Care Programs Unit (HCPU)

The Chief of the HCPU is responsible for:

1) Maintaining direct supervisory authority over the EAP and the EAA;

2) Planning for the budgetary needs of the program and ensuring that these needs are met; and

3) Determining space, equipment and other resource needs that will be required to accomplish the goals established for the EAP.

E. Employee Assistance Program Administrator

The EAA will be assigned on a full-time basis and has the lead role in providing technical expertise as well as direct program administration, which will include planning, organization, implementation, supervision and training responsibilities for the Bureau-wide program. In addition, the EAA will be responsible for:

1) The technical and administrative supervision of the Headquarters EAP Coordinators;

2) Establishing field office EAP Coordinators and providing them with technical supervision and assistance;

3) Overseeing the preparation and submission of annual EAP statistical accomplishment reports to the OPM;

4) Providing consultation to management officials and supervisory staff concerning organizational matters and employees with behavioral problems. Organizational matters are not limited to administrative/operational issues but also include the identification of occupational stressors unique to the FBI, their impact on job-related employee problems and resolution strategies;

5) Ensuring coordination of services between the EAP, the Psychological Services Program and the Behavioral Science Unit;

6) Ensuring that the policies and procedures set forth in this manual and all supporting Federal directives are followed by all employees under his/her supervision. This includes the adherence to confidentiality requirements and other standards of ethical practice;

7) Providing for the design and implementation of a training program for managers, supervisors and employees concerning their roles within the program and publicizing the services that are available;

8) Making recommendations to management officials and supervisory staff concerning the continuing education requirements necessary for EAP personnel;

9) Developing and maintaining a nationwide listing/register of community rehabilitation and treatment resources available for the referral of employees and/or their family members in need of such assistance. This listing shall include:

a) Name, address and telephone number;

b) Types of services provided and educational background/qualifications of service providers;

c) Hours of operation, including emergency hours;

d) A contact person's name and telephone number;

e) Fee structure and insurance coverage;
f) Type of client population served;
g) Assessment/rating of services by participants

and/or EAP Coordinators; and

h.) Other pertinent information;

10) Representing the FBI through liaison with national, state and local organizations which are public, private and professional on matters concerning EAPs;

11) Conducting the necessary evaluation, research and monitoring to ensure program effectiveness;

12) Providing counseling, assessment and referral services to all employees referred by others or upon self-referral; and

13) The coordination and follow-up of employee rehabilitation through communication with community treatment resources.

[The EAA should possess an in depth knowledge in one of the human services fields. Ordinarily, this requirement would be satisfied by a graduate degree in one of the mental health disciplines (e.g., counseling, clinical psychology or social work) and/or by graduation from a four-year college or University with a major in one of the behavioral sciences, specialized training in counseling and five years of work experience in a specialty field germane to the program. The EAA must also have expertise in the areas of alcoholism and drug abuse. In addition, a thorough knowledge of Bureau policies and procedures is required in order to ensure that the EAP adheres to existing organizational guidelines. The EAA should be required to work toward and maintain current professional and addictions treatment certifications/licenses and remain current in his/her field by participation in continuing education opportunities and if applicable, enrollment in an advanced graduate degree program.]

F. Personnel in Charge of Field Offices and Regional Support Centers

Personnel in charge of field offices and regional support centers are responsible for:

1) Designating an individual to serve, on a full-time or part-time basis, as an EAP Coordinator;

2) Knowing the Federal confidentiality regulations cited in this manual and ensuring that EAP Coordinators adhere to these requirements and other standards of ethical practice;

3) Ensuring that EAP Coordinators are allowed sufficient time, as part of their official duties, to effectively implement the program;

4) Providing the necessary space, equipment and other resource needs required to ensure individual confidentiality and the accomplishment of program goals;

5) Ensuring that employees under their supervision in need of EAP services are referred to the EAP Coordinator for assistance;

6) Providing for the training of managers, supervisors and employees concerning their roles within the Program and publicizing the services that are available;

7) Allowing EAP Coordinators the opportunity to participate in continuing education programs in order to maintain their skills and the knowledge base necessary for the effective delivery of services.

G. Employee Assistance Program Coordinator

The EAP Coordinator is responsible for:

1) The implementation and operation of the EAP within their local area (field/Headquarters);

2) Providing short term counseling and referral services to all employees referred to the EAP by others or upon self-referral;

3) Providing consultation with supervisory staff concerning the identification and management of employees with problems that may be adversely affecting job performance;

4) Providing educational materials and training to supervisors in order to familiarize them with their roles and responsibilities within the program;

5) Publicizing the EAP and ensuring that all employees are aware of the services available;

6) Coordination with the DDP Coordinator in order to educate employees about illegal drug abuse in the workplace and the relationship between the DDP and the EAP. (EAP Coordinators are not to be assigned any responsibilities or duties directly under the DDP which would involve the actual drug testing of employees);

7) Referring employees in need of assistance to community treatment/rehabilitation resources and monitoring the employee's progress, through appropriate follow-up, during and after the rehabilitation period. When making referrals EAP Coordinators should consider the following:

a) The nature and severity of the problem(s);

b) Location of treatment services;

c) Level of training and educational background of service provider(s);

d) Cost of treatment;

e) Treatment environment (inpatient/outpatient);

f) Employee insurance coverage;

g) Other special needs of employee; (transportation/child care); and

h) The employee's preference;

8) Adhering to all policies and procedures set forth in this manual and all supporting Federal directives. This includes strict adherence to Federal confidentiality regulations and other standards of ethical practice;

9) Preparing and submitting to the EAA biannual statistical accomplishment reports on employee participation in the program. Information provided in these reports will be for statistical purposes only and will not contain any data that would either directly or indirectly reveal the identity of a participating employee;

10) Conducting periodic evaluations of program effectiveness and when appropriate providing feedback to management officials and the EAA;

11) Maintaining a local listing/register of community rehabilitation and treatment resources utilized for the referral of employees and/or their family members in need of such assistance. This information will also be submitted to the EAA as part of the biannual statistical accomplishment report. This listing shall include:

a) Name, address and telephone number;

b) Types of services provided and educational background/qualifications of service provider(s);

c) Hours of operation, including emergency hours;

d) A contact persons name and telephone number;

e) Fee structure and insurance coverage;

f) Type of client population served;

g) Assessment/rating of services by participants and/or EAP Coordinator; and

h) Other pertinent information;

12) Periodically visiting community treatment/rehabilitation resources for assessment and quality assurance purposes; and

13) Maintaining his/her skills and the knowledge base necessary for the effective delivery of EAP services, by participation in continuing education programs.

H. Management Officials and Supervisors

Management officials and supervisors are responsible for:

1) Supporting the EAP by continually observing and evaluating the work performance of all employees under their supervision;

2) The identification and documentation of specific instances of deteriorating work performance and employee behaviors that fail to meet acceptable standards of conduct;

3) Consulting with the EAP Coordinator or EAA when the employee's problem(s) cannot be resolved by traditional supervisory practices alone and there may be a need for referral to the EAP for corrective action. Managers and supervisors must be able to effectively document and describe the employee's behavior as it relates to work performance but they are not to attempt to diagnose or draw conclusions about an individual's personal problem(s). The preliminary assessment of the nature of the employee's problem(s) is an EAP function, especially when it may involve mental health and/or substance abuse problems;

4) Determining, after consultation with and the concurrence of EAP staff, that referring the employee to the EAP is appropriate;

5) Conducting an interview with the employee focusing on the behaviors that are directly related to poor job performance or deteriorating conduct. Whether or not the employee indicates that his/her difficulty is caused by a personal problem, the supervisor should inform the employee about the EAP services available and offer to refer him/her to the EAP. If the problem persists after the initial consultation with EAP staff, the supervisor should present a firm choice for the employee by encouraging referral acceptance and by describing the consequences of continued unsatisfactory work performance. Participation in the EAP is voluntary and does not preclude supervisors from taking necessary disciplinary action. However, an employee's acceptance or refusal of referral to the EAP and cooperation with community based treatment, if indicated, should be taken into consideration by a supervisor before he/she

proceeds with administrative/disciplinary action. If the employee refuses help and performance continues to be unsatisfactory, the supervisor has complied with his/her program responsibilities and is then obligated to take the necessary adverse action;

6) Ensuring that their referral to the EAP is documented in writing as well as oral. The written documentation is the supervisor's record that the employee has been offered EAP assistance. The EAP staff can assist the supervisor in preparing a memorandum for this purpose, during supervisory consultation sessions. The documented EAP referral should contain the following:

a) Specific instances of poor job performance and deteriorating conduct;

b) A statement indicating that neither the memorandum nor the EAP referral constitutes a disciplinary action;

c) An indication that the supervisor has previously consulted the EAP staff concerning the matter;

d) The fact that the supervisor has outlined the EAP services available and offered referral;

e) The employee's decision whether or not to accept or refuse referral; and

f) The employee's acknowledgement and signature (if the employee refuses to sign, the supervisor shall make a statement to this effect on the memorandum);

This memorandum will not be placed in the employee's Official Personnel Folder. The memorandum will be maintained by the supervisor as part of his/her record keeping system and the Privacy Act prevents it's disclosure beyond the EAP without the employee's written consent. In the event that administrative/ disciplinary action is instituted against an employee who has had a documented offer of EAP assistance and who subsequently denies having received it, the memorandum may become part of the adverse action file to dispute the validity of the employee's claim.

7) Refraining from discussing with the employee the possibility that his/her work performance difficulties may be related to alcohol or drug problems. Again, the supervisor should focus on the employee's job performance only. However, when the employee is at work and does not appear to be in full control of his/her faculties, the supervisor should immediately inquire about the employee's physical/medical condition while being aware that behavioral symptoms commonly associated with

alcohol intoxication and drug abuse can be caused by other health problems. Where applicable, the employee should be immediately referred to the Health Service/Occupational Health Nurse for assessment and emergency treatment. Locations that have no medical personnel should refer the employee to a private physician, community health service or hospital.

Ultimately, if the employee's behavior was determined to be related to alcohol or drug intoxication, the supervisor and/or medical personnel should discuss the facts of the situation with the employee and refer him/her to the EAP.

I. Employee Responsibility/Self-Referral Procedure

Employees who suspect that their work performance has been negatively affected by an emotional, behavioral, alcohol, or drug abuse problem are encouraged to contact the EAP. In addition, EAP services are offered to the members of an employee's family, to the extent feasible, who may also need assistance with a personal problem. Employees seeking assistance can contact the EAP Coordinator in their respective field office/division or the EAA at FBI Headquarters. Communications between an employee's family members and EAP personnel are subject to all applicable confidentiality requirements previously cited in this manual.

When an employee in good faith voluntarily seeks EAP assistance for an illegal drug abuse problem, EAP personnel will not require the employee to waive his/her right to confidentiality before assistance will be provided. Furthermore, if the employee's illegal use of drugs comes to the attention of management subsequent to the employee receiving EAP assistance or successfully completing a rehabilitative program, no disciplinary action will be taken against the employee for illegal drug use. These employees, however, must remain drug free as a subsequent finding of illegal drug use will result in the initiation of disciplinary action as detailed in the DDP.

VII. Coordination With Other Programs

The FBI also provides through other programs (e.g., medical staff, Equal Employment Opportunity Counselors, Peer Support Agents), a limited capability consisting of consultation to supervisors in connection with their dealings with troubled employees and direct counseling to employees. These programs are valuable resources and can play an important role in support of the EAP. A close working relationship between all programs is essential in order to meet the diverse needs of our employees.

Referral to the EAP is always an option available to other program staff/counselors, regardless of the employee's difficulty. Because of the unique nature of alcoholism and drug abuse problems and the complex sets of laws and regulations governing those designated to perform a drug and alcohol abuse

prevention function, staff/counselors in other programs should not undertake such counseling. If staff/counselors in these other related programs are advised by an employee that he/she may have an alcohol or drug problem they should:

a) Immediately refer the employee to an EAP Coordinator;

b) Adhere to confidentiality requirements established by law which include protecting the employee's identity; and

c) Release drug and/or alcohol related information concerning the employee only upon receiving written consent.

VIII. Confidentiality

The confidentiality of employee communications and records concerning EAP referrals and assistance are maintained in accordance with existing Federal laws and regulations. Without a demonstrated respect for the employee's personal privacy, any incentive to voluntarily seek EAP assistance will be diminished and/or destroyed. Corrective action, if it takes place at all, may be postponed until the employee's problem(s) become more serious and more resistant to treatment efforts.

The FBI recognizes that an individual's right to privacy and the organization's need to know, at times, may seem to be at cross-purposes. Therefore, it is essential that all employees understand the scope of confidentiality under this program and the restrictions imposed upon EAP personnel concerning any disclosures of information about employees served by the EAP. All persons performing an EAP function must become thoroughly acquainted with the statutory and regulatory requirements pertaining to the confidentiality of alcohol and drug abuse information (42 CFR, Part 2) (Appendix D herein). Violation of these provisions is a criminal offense subject to the penalties set by law. It is incumbent upon EAP personnel to explain to those seeking assistance the necessity for a balance between the employee's need for anonymity and the need for the protection of themselves and others in those situations where problems are life threatening.

The law requires that information relating to the identity, diagnosis, prognosis or treatment of an employee, which is developed and maintained in connection with an EAP function, is confidential and may be released to others only under the following circumstances:

A. With employee's written consent:

This includes disclosures about the fact that an

employee has even contacted EAP personnel, participated in the program in any way or about any information regarding the employee's problem, unless the employee consents to such disclosure in writing. EAP personnel must discuss this issue during their first contact with an employee to determine the extent and nature of information, if any, to be disclosed to supervisors and/or management officials.

The following items must be included on the consent for Release of Confidential Information Form (Appendix E herein):

1) Name of employee;

2) Name/Title of individual and name of program making disclosure;

3) Name of person, organization or program to which disclosure is to be made;

4) Extent and/or nature of information to be disclosed;

5) Purpose or need for disclosure;

6) A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance, thereon, and a specification of the date, event or condition upon which it will expire without express revocation;

7) Specification concerning date and circumstances of expiration;

8) Date consent granted and form executed;

9) Signature of employee; and

10) Signature of EAP Personnel.

Persons authorized to receive information provided for in an initial disclosure are prohibited from making any redisclosure of this information unless further disclosure is expressly permitted by the written consent. This prohibition includes disclosures by EAP personnel to supervisors, management officials and/or community treatment resources.

Examples of circumstances when disclosure can be made with employee consent are:

1) For purposes of diagnosis, treatment and rehabilitation (e.g., referral to community treatment resources);

2) To an employee's attorney;

3) To an employee's family;

4) To an insurance company, third party payers or other funding sources; and

5) To a supervisor or management official.

In all of the above situations EAP personnel must ensure that consent was given voluntarily and granting the request for disclosure will not be harmful to the employee or the EAP's capacity to provide services.

B. Without employee written consent:

These conditions are purposely limited and include medical emergencies and court orders.

If the EAP Coordinator believes: 1) the employee's mental or physical condition is a threat to the employee's safety or to the safety of others or would otherwise affect the national security or law enforcement operations; or 2) the employee's behavior in conjunction with his/her problem undermines the investigative process, then the EAP Coordinator should immediately advise the EAA at FBI Headquarters who will determine appropriate action.

All disclosures without employee consent are to be made by EAP Coordinators only and following the approval of the EAA and/or guidance from the Legal Counsel Division. In situations where approval from FBI Headquarters is not possible (e.g., medical emergency or imminent threat to life) and disclosure without consent is made, the EAA should be advised as soon as practicable.

IX. Maintenance Of Records

The EAP will maintain only those records necessary to comply with its internal program requirements. These records should be limited to identifying data on those seeking assistance, release forms and other information necessary for referral to community resources. These records will be maintained by EAP personnel only and will be stored in safe-type combination lock file cabinets or if unavailable, traditional locking file cabinets. EAP records and the personnel that maintain them are subject to the FBI's Privacy Act and all applicable laws, statutes and implementing regulations regarding confidentiality of medical, alcohol and drug abuse records. Records pertaining to an employee's participation in the EAP shall not be maintained in his/her Official Personnel Folder.

X. Relationship To Drug Deterrence Program

EAP personnel will be available to accept referral from the DDP when an employee is found to be using drugs illegally. Although the EAP and DDP have as concurrent goals the prevention of illegal drug abuse within the FBI, both are independent programs with separate sets of procedures and distinct roles of their own. The EAP will focus on rehabilitative efforts for employees using illegal drugs, and on preventive measures through employee education. EAP personnel are not to be involved in the collection of urine samples, the reporting of drug test results or the institution of disciplinary action.

In the event of a verified positive drug test, a letter will be prepared by the DDP Coordinator and sent to the employee outlining the EAP services available and providing the names of the EAP personnel who can provide assistance. A copy of this letter will be forwarded to the EAA. Once the referral is made, and if the employee agrees to meet with EAP personnel, EAP personnel will require the employee to sign a Consent for Release of Confidential Information Form to supervisory staff before assistance will be provided. This consent will cover the release of information pertaining to the employee's compliance with the agreed upon treatment plan and provide an avenue of communication back to the supervisor concerning the employee's progress during and at the end of treatment. Conditioning the offer of EAP assistance by the requirement that the employee waive his or her right to confidentiality is a voluntary waiver.

As part of the EAP treatment plan, the employee will be required to enroll in the follow-up drug testing program during or after participation in the rehabilitation process. In such cases, the DDP Coordinator is authorized to initiate the unannounced collection of a urine sample for testing. Thereafter, the procedures for reporting verified positive test results to management will be the same as those detailed by the DDP for reasonable suspicion testing.

XI. Health Insurance and Treatment Costs

The services of the EAP are offered to all employees, and to the extent feasible to their families, at no cost. However, when an individual is referred to a rehabilitative resource within the community, the employee is responsible for the cost of treatment. Alcoholism, drug abuse and other mental health problems are recognized as treatable illnesses which require medical and/or other professional treatment. As such, participating health insurance carriers under the Federal Employee Health Benefits Program, may provide either partial or complete coverage to employees enrolled in such plans. Employees can contact their respective insurance carriers or EAP personnel to determine the extent of coverage available for each specific plan. A variety of other funding sources may be available within the community to provide financial assistance to employees seeking treatment. EAP personnel should be familiar with the eligibility requirements and availability of these programs.

APPENDIX A

Executive Order 12564 of September 15, 1986

Federal Register
Vol. 51. No. 180
Wednesday, September 17, 1986

Presidential Documents

Title 3—

The President

Executive Order 12564 of September 15, 1986

Drug-Free Federal Workplace

I, RONALD REAGAN, President of the United States of America, find that:

Drug use is having serious adverse effects upon a significant proportion of the national work force and results in billions of dollars of lost productivity each year;

The Federal government, as an employer, is concerned with the well-being of its employees, the successful accomplishment of agency missions, and the need to maintain employee productivity;

The Federal government, as the largest employer in the Nation, can and should show the way towards achieving drug-free workplaces through a program designed to offer drug users a helping hand and, at the same time, demonstrating to drug users and potential drug users that drugs will not be tolerated in the Federal workplace;

The profits from illegal drugs provide the single greatest source of income for organized crime, fuel violent street crime, and otherwise contribute to the breakdown of our society;

The use of illegal drugs, on or off duty, by Federal employees is inconsistent not only with the law-abiding behavior expected of all citizens, but also with the special trust placed in such employees as servants of the public;

Federal employees who use illegal drugs, on or off duty, tend to be less productive, less reliable, and prone to greater absenteeism than their fellow employees who do not use illegal drugs;

The use of illegal drugs, on or off duty, by Federal employees impairs the efficiency of Federal departments and agencies, undermines public confidence in them, and makes it more difficult for other employees who do not use illegal drugs to perform their jobs effectively. The use of illegal drugs, on or off duty, by Federal employees also can pose a serious health and safety threat to members of the public and to other Federal employees;

The use of illegal drugs, on or off duty, by Federal employees in certain positions evidences less than the complete reliability, stability, and good judgment that is consistent with access to sensitive information and creates the possibility of coercion, influence, and irresponsible action under pressure that may pose a serious risk to national security, the public safety, and the effective enforcement of the law; and

Federal employees who use illegal drugs must themselves be primarily responsible for changing their behavior and, if necessary, begin the process of rehabilitating themselves.

By the authority vested in me as President by the Constitution and laws of the United States of America, including section 3301(2) of Title 5 of the United States Code, section 7301 of Title 5 of the United States Code, section 290ee–1 of Title 42 of the United States Code, deeming such action in the best interests of national security, public health and safety, law enforcement and the efficiency of the Federal service, and in order to establish standards and procedures to ensure fairness in achieving a drug-free Federal workplace and to protect the privacy of Federal employees, it is hereby ordered as follows:

Section 1. *Drug-Free Workplace.*

(a) Federal employees are required to refrain from the use of illegal drugs.

(b) The use of illegal drugs by Federal employees, whether on duty or off duty, is contrary to the efficiency of the service.

(c) Persons who use illegal drugs are not suitable for Federal employment.

Sec. 2. *Agency Responsibilities.*

(a) The head of each Executive agency shall develop a plan for achieving the objective of a drug-free workplace with due consideration of the rights of the government, the employee, and the general public.

(b) Each agency plan shall include:

(1) A statement of policy setting forth the agency's expectations regarding drug use and the action to be anticipated in response to identified drug use;

(2) Employee Assistance Programs emphasizing high level direction, education, counseling, referral to rehabilitation, and coordination with available community resources;

(3) Supervisory training to assist in identifying and addressing illegal drug use by agency employees;

(4) Provision for self-referrals as well as supervisory referrals to treatment with maximum respect for individual confidentiality consistent with safety and security issues; and

(5) Provision for identifying illegal drug users, including testing on a controlled and carefully monitored basis in accordance with this Order.

Sec. 3. *Drug Testing Programs.*

(a) The head of each Executive agency shall establish a program to test for the use of illegal drugs by employees in sensitive positions. The extent to which such employees are tested and the criteria for such testing shall be determined by the head of each agency, based upon the nature of the agency's mission and its employees' duties, the efficient use of agency resources, and the danger to the public health and safety or national security that could result from the failure of an employee adequately to discharge his or her position.

(b) The head of each Executive agency shall establish a program for voluntary employee drug testing.

(c) In addition to the testing authorized in subsections (a) and (b) of this section, the head of each Executive agency is authorized to test an employee for illegal drug use under the following circumstances:

(1) When there is a reasonable suspicion that any employee uses illegal drugs;

(2) In an examination authorized by the agency regarding an accident or unsafe practice; or

(3) As part of or as a follow-up to counseling or rehabilitation for illegal drug use through an Employee Assistance Program.

(d) The head of each Executive agency is authorized to test any applicant for illegal drug use.

Sec. 4. *Drug Testing Procedures.*

(a) Sixty days prior to the implementation of a drug testing program pursuant to this Order, agencies shall notify employees that testing for use of illegal drugs is to be conducted and that they may seek counseling and rehabilitation and inform them of the procedures for obtaining such assistance through the agency's Employee Assistance Program. Agency drug testing programs already ongoing are exempted from the 60-day notice requirement. Agencies may take action under section 3(c) of this Order without reference to the 60-day notice period.

(b) Before conducting a drug test, the agency shall inform the employee to be tested of the opportunity to submit medical documentation that may support a legitimate use for a specific drug.

(c) Drug testing programs shall contain procedures for timely submission of requests for retention of records and specimens; procedures for retesting; and procedures, consistent with applicable law, to protect the confidentiality of test results and related medical and rehabilitation records. Procedures for providing urine specimens must allow individual privacy, unless the agency has reason to believe that a particular individual may alter or substitute the specimen to be provided.

(d) The Secretary of Health and Human Services is authorized to promulgate scientific and technical guidelines for drug testing programs, and agencies shall conduct their drug testing programs in accordance with these guidelines once promulgated.

Sec. 5. *Personnel Actions.*

(a) Agencies shall, in addition to any appropriate personnel actions, refer any employee who is found to use illegal drugs to an Employee Assistance Program for assessment, counseling, and referral for treatment or rehabilitation as appropriate.

(b) Agencies shall initiate action to discipline any employee who is found to use illegal drugs, *provided that* such action is not required for an employee who:

(1) Voluntarily identifies himself as a user of illegal drugs or who volunteers for drug testing pursuant to section 3(b) of this Order, prior to being identified through other means;

(2) Obtains counseling or rehabilitation through an Employee Assistance Program; and

(3) Thereafter refrains from using illegal drugs.

(c) Agencies shall not allow any employee to remain on duty in a sensitive position who is found to use illegal drugs, prior to successful completion of rehabilitation through an Employee Assistance Program. However, as part of a rehabilitation or counseling program, the head of an Executive agency may, in his or her discretion, allow an employee to return to duty in a sensitive position if it is determined that this action would not pose a danger to public health or safety or the national security.

(d) Agencies shall initiate action to remove from the service any employee who is found to use illegal drugs and:

(1) Refuses to obtain counseling or rehabilitation through an Employee Assistance Program; or

(2) Does not thereafter refrain from using illegal drugs.

(e) The results of a drug test and information developed by the agency in the course of the drug testing of the employee may be considered in processing any adverse action against the employee or for other administrative purposes. Preliminary test results may not be used in an administrative proceeding unless they are confirmed by a second analysis of the same sample or unless the employee confirms the accuracy of the initial test by admitting the use of illegal drugs.

(f) The determination of an agency that an employee uses illegal drugs can be made on the basis of any appropriate evidence, including direct observation, a criminal conviction, administrative inquiry, or the results of an authorized testing program. Positive drug test results may be rebutted by other evidence that an employee has not used illegal drugs.

(g) Any action to discipline an employee who is using illegal drugs (including removal from the service, if appropriate) shall be taken in compliance with otherwise applicable procedures, including the Civil Service Reform Act

(h) Drug testing shall not be conducted pursuant to this Order for the purpose of gathering evidence for use in criminal proceedings. Agencies are not required to report to the Attorney General for investigation or prosecution any information, allegation, or evidence relating to violations of Title 21 of the United States Code received as a result of the operation of drug testing programs established pursuant to this Order.

Sec. 6. *Coordination of Agency Programs.*

(a) The Director of the Office of Personnel Management shall:

(1) Issue government-wide guidance to agencies on the implementation of the terms of this Order;

(2) Ensure that appropriate coverage for drug abuse is maintained for employees and their families under the Federal Employees Health Benefits Program;

(3) Develop a model Employee Assistance Program for Federal agencies and assist the agencies in putting programs in place;

(4) In consultation with the Secretary of Health and Human Services, develop and improve training programs for Federal supervisors and managers on illegal drug use; and

(5) In cooperation with the Secretary of Health and Human Services and heads of Executive agencies, mount an intensive drug awareness campaign throughout the Federal work force.

(b) The Attorney General shall render legal advice regarding the implementation of this Order and shall be consulted with regard to all guidelines, regulations, and policies proposed to be adopted pursuant to this Order.

(c) Nothing in this Order shall be deemed to limit the authorities of the Director of Central Intelligence under the National Security Act of 1947, as amended, or the statutory authorities of the National Security Agency or the Defense Intelligence Agency. Implementation of this Order within the Intelligence Community, as defined in Executive Order No. 12333, shall be subject to the approval of the head of the affected agency.

Sec. 7. *Definitions.*

(a) This Order applies to all agencies of the Executive Branch.

(b) For purposes of this Order, the term "agency" means an Executive agency, as defined in 5 U.S.C. 105; the Uniformed Services, as defined in 5 U.S.C. 2101(3) (but excluding the armed forces as defined by 5 U.S.C. 2101(2)); or any other employing unit or authority of the Federal government, except the United States Postal Service, the Postal Rate Commission, and employing units or authorities in the Judicial and Legislative Branches.

(c) For purposes of this Order, the term "illegal drugs" means a controlled substance included in Schedule I or II, as defined by section 802(6) of Title 21 of the United States Code, the possession of which is unlawful under chapter 13 of that Title. The term "illegal drugs" does not mean the use of a controlled substance pursuant to a valid prescription or other uses authorized by law.

(d) For purposes of this Order, the term "employee in a sensitive position" refers to:

(1) An employee in a position that an agency head designates Special Sensitive, Critical-Sensitive, or Noncritical-Sensitive under Chapter 731 of the Federal Personnel Manual or an employee in a position that an agency head designates as sensitive in accordance with Executive Order No. 10450, as amended;

(2) An employee who has been granted access to classified information or may be granted access to classified information pursuant to a determination of trustworthiness by an agency head under Section 4 of Executive Order No. 12356;

(3) Individuals serving under Presidential appointments;

(4) Law enforcement officers as defined in 5 U.S.C. 8331(20); and

(5) Other positions that the agency head determines involve law enforcement, national security, the protection of life and property, public health or safety, or other functions requiring a high degree of trust and confidence.

(e) For purposes of this Order, the term "employee" means all persons appointed in the Civil Service as described in 5 U.S.C. 2105 (but excluding persons appointed in the armed services as defined in 5 U.S.C. 2102(2)).

(f) For purposes of this Order, the term "Employee Assistance Program" means agency-based counseling programs that offer assessment, short-term counseling, and referral services to employees for a wide range of drug, alcohol, and mental health programs that affect employee job performance. Employee Assistance Programs are responsible for referring drug-using employees for rehabilitation and for monitoring employees' progress while in treatment.

Sec. 8. *Effective Date.* This Order is effective immediately.

Ronald Reagan

THE WHITE HOUSE,
September 15, 1986.

[FR Doc. 86-21166
Filed 9-15-86; 3:47 pm]
Billing code 3195-01-M

Editorial note: For the President's remarks of September 15 on signing EO 12564, see the *Weekly Compilation of Presidential Documents* (vol. 22, no. 38).

APPENDIX B

FPM Letter 792-16 of November 28, 1986

Federal Personnel Manual System

FPM Letter 792-16

Published in advance of incorporation in FPM Supp. 792-2
RETAIN UNTIL SUPERSEDED

Washington, D. C. 20415
November 28, 1986

SUBJECT: Establishing a Drug-Free Federal Workplace

Heads of Departments and Independent Establishments:

1. PURPOSE.

a. The use of illegal drugs by a significant proportion of the national workforce has major adverse effects on the welfare of all Americans, and results in billions of dollars of lost productivity each year. There is no reason to believe that there is a greater incidence of illegal drug use in the Federal workforce than in the private workforce. However, as the Nation's largest employer, the Federal government and its two million civilian employees must be in the forefront of our national effort to eliminate illegal drugs from the American workplace.

b. The use of illegal drugs by Federal employees, whether on or off the job, cannot be tolerated. Employees who use illegal drugs have three to four times more accidents while at work. Federal workers have a right to a safe and secure workplace, and all American citizens, who daily depend on the work of the Federal government for their health, safety, and security, have a right to a reliable and productive civil service. Federal agencies must take action for the protection of individual drug users, their co-workers, and the society at large. In recognition of this, President Reagan, in Executive Order 12564, set forth the policy of the United States Government to eliminate drug use from the Federal workplace.

c. Agencies will establish a comprehensive drug prevention program which is humane, responsible, and effective. In recognition that employees who use drugs are, themselves, primarily responsible for changing their behavior, the program will include drug education and training, employee counseling and assistance, and voluntary drug testing. However, where appropriate, there will be mandatory drug testing and disciplinary action.

d. This will be a balanced program which emphasizes offering a helping hand to employees who are using illegal drugs. At the same time, it must be clear to all that continued illegal drug use by employees will not be tolerated.

e. Under the Executive Order, OPM is directed to issue government-wide guidance to agencies on the implementation of the terms of the Order.

2. AGENCY RESPONSIBILITIES.

a. The head of each Executive agency shall develop a plan for achieving the objective of a drug-free workplace with due consideration of rights of the government, and the employee. Agencies should make every

---

quiries: Office of the General Counsel, (202) 632-4633

de: 792, Federal Employees' Health and Counseling Programs

Distribution: Basic FPM, FPM Supplement 792-2

reasonable effort to ensure workforce understanding of, and employee organization cooperation with, their drug prevention programs. Communications should emphasize the importance of the drug prevention program for agency mission and the community at large. Further, agencies should ensure that their drug prevention programs complement agency programs to deal with alcohol abuse and related employee problems.

b. Each agency plan shall include:

(1) A statement of policy setting forth the agency's expectations regarding drug use and the action to be anticipated in response to identified drug use;

(2) Employee Assistance Programs (EAP's) with high level direction, emphasizing education, counseling, referral to rehabilitation, and coordination with available community resources;

(3) Supervisory training to assist in identifying and addressing illegal drug use by agency employees (agencies may wish to include material on alcohol abuse in this training);

(4) Provision for self-referral as well as supervisory referrals to counseling or treatment with maximum respect for individual confidentiality consistent with safety and security; and

(5) Provision for identifying illegal drug users, including testing on a controlled and carefully monitored basis in accordance with E.O. 12564 and the guidance contained below.

c. Agencies shall ensure that drug testing programs in existence as of September 15, 1986, are brought into conformance with E.O.12564.

d. Agencies should consult with the Attorney General regarding their drug testing programs, as provided by Section 6(b) of the Order.

3. AGENCY DRUG TESTING PROGRAMS.

a. Random and Comprehensive Testing in Sensitive Positions. The head of each Executive agency shall establish a program to test for the use of illegal drugs by employees in sensitive positions.

(1) For purposes of this program, the term "employee(s) in a sensitive position" refers to:

(a) An employee in a position that an agency head designates Special Sensitive, Critical-Sensitive, or Noncritical-Sensitive under Chapter 731 of the Federal Personnel Manual or an employee in a position that an agency head designates as sensitive in accordance with Executive Order No. 10450, as amended;

(b) An employee who has been granted access to classified information or may be granted access to classified information pursuant to a determination of trustworthiness by an agency head under Section 4 of Executive Order No. 12356;

(c) Individuals serving under Presidential appointments;

(d) Law enforcement officers as defined in 5 U.S.C. 8321 (20); and

(e) Other positions that the agency head determines involve law enforcement, national security, the protection of life and property, public health or safety, or other functions requiring a high degree of trust and confidence.

(2) The head of each agency has discretion to determine which sensitive positions for which random testing is authorized should be subject to such testing. This determination should be based on the nature of the agency's mission, its employees' duties, the efficient use of agency resources, and the danger that could result from the failure of an employee to discharge his or her duties adequately. Thus, who will actually be tested is a function of a two step analysis by the agency head.

(a) First, the criteria set forth in Section 7(d) of Executive Order 12564 must be applied to all employees in the agency to determine which employees fall into the "pool" of employees potentially subject to drug testing; this is the pool of "employees in sensitive positions" as defined in the Executive Order. While the definition of the pool of "employees in sensitive positions" is the same from agency to agency, the testing of all employees in that pool may be appropriate for some agencies and not for others depending upon the duties of the positions and the missions of the agencies. If an agency head decides not to test all employees in the pool, then a further determination must be made as outlined below.

(b) Second, a determination must then be made from this pool as to which positions will actually be tested. For the sake of clarity within this guidance, this second group of positions is referred to as testing designated positions. Thus, an agency head may determine not to designate all sensitive positions as testing designated positions, but may limit testing to certain positions. For instance, this may include positions where national security considerations are present, as well as positions where there is a clear impact on public health or safety (e.g., air traffic controllers; operators of motor vehicles; medical, nursing, and related health care personnel) or positions relating to illegal drug control (e.g., law enforcement officers such as customs agents and drug enforcement agents). Other positions should be reviewed with particular care when one or more of the following are present as regular, recurring duties: operation or maintenance of any transportation, motor vehicle, aircraft, or heavy or other large mechanical or electrical equipment; work with explosive, toxic, radioactive, or other dangerous materials; work with fluids or gases under heat or pressure; work by employees uniquely positioned to exploit highly sensitive computer or financial data for financial gain.

(3) When selecting testing designated positions, agencies should ensure that the selection process does not result in arbitrary, capricious, or discriminatory selections. Agencies must be able to justify their selection of testing designated positions as a neutral application of the selection criteria set forth in section 3.a.(2)(b), above. Agencies are absolutely prohibited from selecting positions for drug testing on the basis of a desire to test particular individual employees.

(4) Individuals in testing designated positions may be selected for random testing in a variety of ways. For example, their names or social security numbers may be selected randomly by computer, they may be selected according to their birth dates, or they may be selected by the first letter in their surnames.

(5) Random testing contemplates unscheduled testing and random sampling of the employees within the group of testing designated positions. As an alternative to random testing, the head of an agency may, at his or her discretion, designate that all employees in testing designated positions shall be tested.

b. Voluntary Testing. The head of each Executive agency shall establish a program for voluntary employee drug testing that allows employees to participate in the drug testing program. An agency should afford an opportunity for any employee to step forward and be tested at a time determined by the agency.

c. Reasonable Suspicion Testing. In addition to the testing outlined in subsections a. and b. of this section, the head of each Executive agency is authorized to test an employee when there is a reasonable suspicion that any employee uses illegal drugs. For the purposes of this program "reasonable suspicion" is an articulable belief that an employee uses illegal drugs drawn from specific and particularized facts and reasonable inferences from those facts.

(1) Prompt supervisory training to assist in identifying and addressing illegal drug use by agency employees should be provided to supervisors as each agency develops and implements its agency program. Such training will make supervisors more sensitive to employee behavior and help supervisors recognize those facts that give rise to a reasonable suspicion.

(2) "Reasonable suspicion" that an employee uses illegal drugs may be based upon, among other things:

(a) observable phenomena, such as direct observation of drug use and/or the physical symptoms of being under the influences of a drug;

(b) a pattern of abnormal conduct or erratic behavior;

(c) arrest or conviction for a drug related offense; or the identification of an employee as the focus of a criminal investigation into illegal drug possession, use, or trafficking;

(d) information provided either by reliable and credible sources or independently corroborated; or

(e) newly discovered evidence that the employee has tampered with a previous drug test.

(3) Where testing is conducted based on reasonable suspicion, each agency should promptly detail in writing the circumstances which formed the basis of its determination that reasonable suspicion exists to warrant the testing. Such documentation should be retained in the adverse action file compiled by the agency.

d. Specific Condition Testing. The head of each agency is also authorized to test an employee for illegal drug use in an examination authorized by the agency regarding an accident or unsafe practice.

e. Followup Testing. The head of each agency may also require agency administered followup drug test during or after counseling or rehabilitation for illegal drug use through an Employee Assistance Program. While followup testing may be undertaken as a part of counseling or rehabilitation under the Employee Assistance Program, only the results of agency-administered followup testing may be used, if confirmed positive results are obtained, to support an adverse action taken under section 5(d)(2) of the Executive Order. Such agency-administered followup testing should be unannounced.

f. Applicant Testing. The head of each Executive agency is authorized, but not required, to test any applicant for illegal drug use. Agency heads who choose to test applicants for illegal drug use have a variety of options. For example, depending on the mission of the agency, an agency may wish to test all applicants for employment. On the other hand, an agency may determine that it will limit applicant testing to applicants for testing designated positions. Where an applicant must submit to a physical examination as a condition of employment, an agency may wish to require a drug test as part of the physical examination procedures.

(1) Agencies should include notice of drug testing on vacancy announcements for those positions where drug testing is required. A sample notice provision for vacancy announcements or other information about the position would read as follows: "All applicants for this position will be required to submit to a urinalysis for illegal drug use prior to appointment in the Federal service."

(2) Where applicants are given preemployment physical examinations, drug testing may be performed as part of the physical examination procedures. Where no physical examinations are required, applicants should be contacted and directed to report to a designated contractor or agency facility for their drug test. Before conducting a drug test, all applicants should be advised of the opportunity to submit medical documentation that may support a legitimate use for a specific drug. Aside from the general notice of the drug testing requirement in vacancy announcements, applicants should receive as little notice as possible of the actual date and time of their drug test. A urine specimen should be taken no more than forty-eight hours after the applicant is contacted to set up the drug testing.

(3) In remote locations, applicants should be directed to report to the nearest contractor or agency facility. Agencies shall provide for reimbursement to applicants for reasonable expenses incurred in travel to the drug testing facility. In extremely remote areas, the contractor may be required to travel periodically to the region to perform drug testing of applicants.

(4) All applicants with confirmed positive test results shall be refused employment.

g. Hardship Exemption. Agencies may choose to exempt certain positions from the drug testing program on the basis of hardship due to the remote location of the duty station of the positions, the unavailability of on-site testing personnel, or the lack of an appropriate site for test administration. Agencies should, however, use reasonable means to overcome such hardships.

4. DRUG TESTING PROCEDURES.

a. 60 Day General Notice to All Employees.

(1) Agencies which have not yet implemented a drug testing program shall ensure that at least sixty days elapse between a general one-time notice to all employees that a drug testing program is being implemented and the beginning of actual drug testing. Such notice should indicate the purpose of the drug testing program, the availability of counseling and rehabilitation assistance through the agency's Employee Assistance Program, when testing will commence, the general categories of employees to be tested, and the general parameters of testing. Agencies may decide to include with their notice a description of their drug program or a copy of the internal personnel rules establishing their program.

(2) Agencies with drug testing programs already in place prior to issuance of Executive Order 12564 on September 15, 1986, are not required to stop testing and provide a 60 day notice period.

(3) Any agency may take action as described in parts 3.c. and 3.d. of this letter without reference to the 60 day notice requirement.

b. Special Notice to Covered Employees. Agencies should ensure a specific notice is given, in writing, to each employee in a testing designated position no later than thirty days before testing commences. We recommend that agencies obtain a written acknowledgement of receipt of the notice. A sample acknowledgement for agency consideration is provided as attachment 1 to this letter. The notice should contain the following information:

(1) The reasons for the urinalysis test, consistent with agency policy formulated in accordance with sections 1 and 3.a. of this letter.

(2) Notice of the opportunity for an employee to identify himself voluntarily as a user of illegal drugs willing to undertake counseling and, as necessary, rehabilitation, in which case disciplinary action is not required.

(3) Assurance that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable, and that test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.

(4) Notice of the opportunity and procedures for submitting supplemental medical documentation that may support a legitimate use for a specific drug.

(5) The circumstances under which testing may occur, consistent with the policy set forward in section 3 of this letter.

(6) The consequences of a confirmed positive result or refusal to be tested, including disciplinary action.

(7) The availability of drug abuse counseling and referral services, including the name and telephone number of the local Employee Assistance Program counselor.

c. Notice to Employees Tested Under Specific Conditions. Employees being tested under conditions outlined in section 3.c., 3.d., and 3.e. will receive

notice that includes information contained in section 4.b., paragraphs (1), (3), (4), (6), and (7).

d. Agency Response to Persons Refusing to Participate in a Required Drug Test.

(1) To maintain the integrity of the testing and enforcement program, agencies must take disciplinary action to deal with employees who refuse to be tested. Such action may include, but is not necessarily limited to, removal of such employees as failing to meet a condition of employment.

(2) Applicants who are not current employees and who refuse to be tested must be refused that employment.

e. Technical Guidelines for Drug Testing. The Secretary of Health and Human Services, as directed by Executive Order No. 12564, will issue scientific and technical guidelines for drug testing programs. Agencies will conduct their drug testing programs in accordance with those scientific and technical guidelines.

f. Confidentiality of Test Results. Agency drug testing programs under E.O. 12564 shall contain procedures to protect the confidentiality of test results and related medical and rehabilitation records.

(1) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with performance of a drug abuse prevention program conducted by a Federal agency must be kept confidential and may be disclosed only under limited circumstances and for specific purposes. Agencies may wish to refer to regulations issued by the Department of Health and Human Services (42 C.F.R.§2.1, et seq. (1986)) on maintaining the confidentiality of treatment records.

(2) Drug abuse treatment records may be disclosed without the consent of the patient only:

(a) to medical personnel to the extent necessary to meet a genuine medical emergency;

(b) to qualified personnel for conducting scientific research, management audits, financial audits, or program evaluation, with all identifying information removed from the data; or

(c) if authorized by an appropriate court order granted after application showing good cause.

(3) Any other disclosure may be made only with the written consent of the patient, and only under the circumstances set out below. Such consensual disclosure may be made to the patient's employer for verification of treatment or a general evaluation of treatment progress.

(4) Agency drug testing programs should include confidentiality protections consistent with the above requirements. These protections should extend to drug testing records as well as to treatment and rehabilitation records.

(5) Accordingly, neither drug test results nor drug abuse treatment or rehabilitation records may be otherwise disclosed by agencies without the consent of the employee involved. A sample consent for release of patient

information during and after treatment or rehabilitation and a sample release memorandum are included in attachments 2 and 3, respectively. Any disclosure without such consent is strictly prohibited.

(6) As part of the drug testing procedure, agencies should obtain consent to disclose confirmed positive test results to the agency's medical review official (as defined in the HHS guidelines), the administrator of the agency Employee Assistance Program (EAP), and to the management official empowered to recommend or take action. This consent must be obtained prior to the test itself. Consequently, refusal to consent to release of this information will be considered a refusal to take the test.

(7) As provided by the employee consent, confirmed positive test results will be forwarded to the agency EAP program administrator and to the management official empowered to recommend or take action. Records of unconfirmed positive test results and negative test results will be destroyed by the laboratory.

g. Privacy in Drug Testing. Agency drug testing procedures under E.O. 12564 must allow individual privacy unless the agency has reason to believe that a particular individual may alter or substitute the specimen to be provided. Employees and applicants required to be tested shall be made aware of the opportunity to request privacy in the collection of the sample.

(1) If an employee or applicant to be tested requests privacy, the sample shall be provided in a rest room stall or similar enclosure so that the employee is not being viewed while providing the sample. However, this requirement does not restrict the ability of the employer to control the test area and to take other actions to ensure that the employee does not substitute or tamper with the sample. For example, the employer may: (a) control the test area to ensure that samples have not been hidden for substitution; (b) prohibit the carrying of bags, luggage, briefcases, or other containers into the test area; (c) prohibit the wearing of coats and/or jackets in the test area; (d) station a testing official in the rest room outside the stall where visual observation is not possible, but where the official can monitor the setting for tampering; (e) examine the sample after it is provided for abnormalities in color, temperature, or other evidence that tampering may have occurred.

(2) In the event that employees or applicants do not request individual privacy, the agency may provide that the provision of the sample may be observed by a testing official.

(3) Agencies should provide guidance on the circumstances when observation may be required. Generally, an employee or applicant may be required to provide a sample under observation if there is reason to believe that the employee or applicant may alter or substitute the urine specimen. For example, employers may wish to require observation when facts and circumstances suggest that the person to be tested: (a) is an illegal drug user; (b) is under the influence of drugs at the time of the test; (c) has previously been confirmed by the agency to be an illegal drug user; (d) is seen to have equipment or implements used to tamper with urine samples; (e) has recently been determined to have tampered with a sample.

5. AGENCY ACTION UPON FINDING THAT AN EMPLOYEE USES ILLEGAL DRUGS.

a. Drug Use Determination. The determination that an employee uses illegal drugs may be made on the basis of direct observation, a criminal conviction,

confirmed results of the agency's drug testing program, the employee's own admission, or other appropriate administrative determinations.

b. Mandatory Removal from Sensitive Positions. While removal of an employee confirmed to use illegal drugs is authorized under the Executive Order, removal from the Federal service is required after a second determination that the employee uses illegal drugs. If occupying a sensitive position, the employee must not be allowed to remain on duty status in that position. Removal of a sensitive employee determined to use illegal drugs may be required if there are no non-sensitive positions to which the employee may be transferred in the agency, unless the agency head determines that maintaining the employee in the sensitive position would not pose a danger to public health or safety or the national security.

c. Mandatory EAP Referral. Upon reaching a finding that an employee uses illegal drugs, agencies will refer the employee to an Employee Assistance Program and give the employee an opportunity to undertake rehabilitation. While agencies should provide reasonable assistance to employees who demonstrate a desire to become drug-free, the ultimate responsibility to be drug-free rests with the individual employee.

d. Discretionary Disciplinary Actions. Upon the first confirmed determination that an employee uses illegal drugs, there are a range of disciplinary actions available to an agency, from a written reprimand to removal. Except for employees who voluntarily identify themselves as users of illegal drugs, obtain appropriate counseling and rehabilitation, and thereafter refrain from illegal drug use, agencies are required to initiate disciplinary action against employees who are found to use illegal drugs. Agencies have discretion in deciding what disciplinary measures to initiate, consistent with the requirements of the Civil Service Reform Act and other appropriate factors. Among the disciplinary measures available to agencies are the following:

(1) Reprimanding the employee in writing.

(2) Placing the employee in an enforced leave status, consistent with the procedural requirements of 5 C.F.R. 752.203 or 752.404 as appropriate.

(3) Suspending the employee for fourteen days or less consistent with the procedural requirements in 5 C.F.R. 752.203.

(4) Suspending the employee for 15 days or more consistent with the procedural requirements in 5 C.F.R. 752.404.

(5) Suspending the employee, consistent with the procedural requirements in 5 C.F.R. 752.404, until such time as he or she successfully completes counseling or rehabilitation or until the agency determines that action other than suspension is more appropriate to the individual situation.

(6) Removing the employee from Federal service, consistent with the procedural requirements of 5 C.F.R. 752.404, for: confirmed illicit use of an illegal drug; refusal to take a drug test authorized by E.O. 12564; refusal to obtain or successfully complete counseling or rehabilitation as required by the Executive Order; or once having completed counseling or rehabilitation, failing to refrain from illegal drug use.

(7) Separating the employee from Federal service is mandatory upon a second confirmed finding of illegal drug use.

e. Preponderance of Evidence Requirement. Agencies are reminded that any action, including removal, taken against an employee under title 5 United States Code, Chapter 75, must be supported by a preponderance of the evidence. Care must be taken in the conduct of tests and the handling of testing samples to ensure that requirements of evidentiary proof may be met.

6. STATISTICAL REPORTING. Agencies shall keep statistical records on: (1) the number of employees tested and the number of employees with confirmed positive tests; and (2) the number of applicants tested and the number of applicants with confirmed positive tests. Personally identifying information in these statistical records is strictly prohibited.

7. EMPLOYEE COUNSELING AND ASSISTANCE.

a. Program Requirement. Federal agencies are required by Public Law 92-255, as amended, and by 5 C.F.R. 792 to establish programs for appropriate prevention, treatment and rehabilitation of Federal civilian employees with drug abuse problems. Agencies are authorized to establish Employee Assistance Programs to meet this mandate.

b. EAP Requirement. Executive Order 12564 identifies Employee Assistance Programs as an essential element to an agency's plan to achieve a drug-free workforce, and explicitly states that agencies shall refer all employees found to be using illegal drugs to their Employee Assistance Program for assessment, counseling, and referral for treatment or rehabilitation as appropriate.

c. EAP Role. Employee Assistance Programs play an important role in identifying and resolving employee substance abuse by: demonstrating the agency's commitment to eliminating illegal drug use; providing employees an opportunity, with appropriate assistance, to discontinue their drug abuse; providing educational materials to managers, supervisors and employees on drug abuse issues; assisting supervisors in confronting employees who have performance and/or conduct problems which may be based in substance abuse; assessing employee-client problems and making referrals to appropriate treatment and rehabilitation facilities; and followup with individuals during the rehabilitation period to track their progress and encourage successful completion of the program.

d. EAP Elements. In keeping with Executive Order 12564, agencies should ensure that:

(1) EAP's are available to all employees, including those located outside of the Washington metropolitan area and major regional cities. Agencies are encouraged to explore a variety of means for meeting this requirement, including private contractors and cooperative arrangements with other Federal agencies, State and local governments, and non-profit organizations.

(2) At sites where it is not feasible to establish a continuing EAP, agencies should arrange for employee access on a "needs" basis to comparable local resources or to services of established EAP's in other locations.

(3) EAP's, whether in-house or operated through contract, are adequately staffed with fully qualified individuals who can:

(a) Provide counseling and assistance to employees who self-refer for treatment or whose drug tests have been confirmed positive,

and monitor the employees' progress through treatment and rehabilitation;

(b) Provide needed education and training to all levels of the organization on types and effects of drugs, symptoms of drug use and its impact on performance and conduct, relationship of the employee assistance program with the drug testing program, and related treatment, rehabilitation, and confidentiality issues;

(c) Ensure that the confidentiality of test results and related medical and rehabilitation records are maintained in accordance with the specific requirements contained in Public Laws 92-255 and 93-282, with regulations published in 42 C.F.R., Part 2, and with guidance contained in Section 4. of this Letter.

(4) Adequate treatment resources have been identified in the community in order to facilitate referral of drug abuse clients.

(5) All employees in the agency are informed about the EAP and its services.

(6) The Employee Assistance Program plays an appropriate role in the development and implementation of the agency's drug testing program. EAP's should not be involved in the collection of urine samples or the initial reporting of the results of drug tests, but rather be a critical component in the agency's efforts to counsel and rehabilitate drug-abusing employees, as well as in educating the workforce on drug abuse and its symptoms.

e. Further EAP Assistance.

(1) Attachment 4 provides a list of consortia throughout the United States. Agencies wishing to join an existing consortium should contact the individual listed regarding that possibility.

(2) Attachment 5 provides the names and addresses of organizations which have developed information on treatment facilities in the Washington, D.C. area and throughout the U.S.

(3) The Model Employee Assistance Program provided as attachment 6 addresses those functions we consider essential for an EAP to provide in support of the President's drug-free workplace initiative. It should be of use to agencies in developing new EAP's and in assessing the adequacy of existing programs. OPM's Employee Health Services Branch (Tel. FTS 632-5558) is available for technical assistance on these provisions.

Constance Horner

Constance Horner
Director

Attachments

-SAMPLE-

CONSENT FOR RELEASE OF PATIENT INFORMATION DURING OR AFTER TREATMENT OR REHABILITATION

I, _____, hereby consent to the disclosure of
(Employee/Patient name)
information concerning my progress in terminating illegal drug use. I authorize the _____ to disclose that information to
(Treatment/Rehabilitation Facility)

_____, director of the Employee Assistance Program
(Name)
at _____ and to _____, my supervisor
(Name of Agency) (Name of supervisor)
and to the agency Medical Review Official for drug use monitoring under Executive Order 12564, which provides for a drug-free Federal workplace.

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, and that it will expire without express revocation upon
_____.
(date, event, condition.)

This consent to disclose the above-described treatment records was freely given, without reservation, for the purpose set out above.

_____
(Signature of employee/patient)

_____
(Date on which consent is signed)

CLAUSE FOR USE IF EMPLOYEE IS A MINOR OR LEGALLY INCOMPETENT

I, _____, the [parent/legal guardian or personal
(Name)
legal representative] of the above named employee/patient, hereby consent to the aforementioned release of information on his/her behalf.

_____
(Signature)

_____
(Date)

-SAMPLE-

[AGENCY NAME]

ACKNOWLEDGEMENT OF NOTICE TO EMPLOYEES WHOSE POSITION IS DESIGNATED SENSITIVE FOR DRUG TESTING PURPOSES

I acknowledge receiving notice of the establishment of [agency name]'s employee drug testing program. I understand that I may be selected for screening by urinalysis testing for the presence of controlled substances. I understand that a confirmed positive result of that testing or refusal to submit to testing may result in disciplinary action up to and including dismissal from the Federal service.

I have read the notice announcing the establishment of an employee drug testing program.

_____
Printed or Typed Name

_____
Signature of Employee

_____
Date

-SAMPLE-

RELEASE MEMORANDUM

SUBJECT: Release of Patient Information

FROM: [Program making the disclosure.]

TO: [Name or title of the person or organization to which the disclosure is to be made.]

In accordance with the attached "Consent for Release of Patient Information," we have released information to you on [Patient's name].

This information has been disclosed to you from records whose confidentiality is protected by Federal law. See 42 U.S.C. § 290ee-3. Federal regulations, at 42 C.F.R. Part 2, prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by those regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

(Note: This memorandum is substantially the same as the one appearing in Appendix D of FPM Supplement 792-2.)

CURRENT OPERATING CONSORTIA

GEOGRAPHIC LOCATION	LEAD AGENCY	POINT OF CONTACT	TELE NO.
ANCHORAGE, AK	FAA	JAMES OLIVER	907-271-5875
ATLANTA, GA	HHS	MARILYN MONTGOMERY	242-2713
BOSTON, MA	OPM	JOAN KENNEDY	223-2273
BUFFALO, NY	HHS	BOB MAZZOCHI	264-5505
CHICAGO, IL	PHS	FRANCES WENCE	353-1719
CINCINNATI, OH	PHS	FRANCES WENCE	353-1719
DALLAS, TX	HHS	MARY PERKINS	729-3126
DENVER, CO	PHS	DR. R. LORITSCHER	776-0078
KANSAS CITY, MO	HHS	JOHN MCCLAY	758-3597
LONG ISLAND, NY	HHS	BOB MAZZOCHI	264-5505
STATE OF MICHIGAN	PHS	FRANCES WENCE	353-1719
NEWARK, NJ	HHS	BOB MAZZOCHI	264-5505
NEW YORK CITY, NY	HHS	BOB MAZZOCHI	264-5505
PHILADELPHIA, PA	HHS	BEVERLY JANDA	596-6712
SAN JUAN, PR	HHS	BOB MAZZOCHI	264-5505
SEATTLE, WA	ARMY CORP OF ENG.	TERRY CONOVER	206-764-3568
VIRGIN ISLANDS	HHS	BOB MAZZOCHI	264-5505
WASHINGTON, DC	PHS	AMY BARKIN (PHS) CAROL BAPE (OPM)	443-4357 653-8438

TREATMENT FACILITY DIRECTORIES

1. National Directory of Drug Abuse and Alcoholism Treatment and Prevention Program, Stock No. 017024-01252-1, Cost: $16.00

   Available from: Superintendent of Documents
   Government Printing Office
   Washington, D.C. 20402
   Tele: (202) 783-3238

2. Washington Metropolitan Area Directory of Alcohol/Drug Treatment Resources, OPM WPS-01, September 1984, No Cost

   Available from: Office of Personnel Management
   Employee Health Services Branch (PSOG)
   1900 E. Street, N.W. Room 7H39
   Washington, D.C. 20415
   Tele: (202) 632-5558

3. Coping Catalog (listing resources available in the Washington Metropolitan Area for alcohol, drugs and other addictions problems) Updated catalog expected to be available December 1986. Cost to be determined.

   Available from: The Washington Area Council on Alcohol and Drug Abuse
   1221 Massachusetts Ave., N.W.
   Washington, D.C. 20005
   Tele: (202) 783-1300

MODEL EMPLOYEE ASSISTANCE PROGRAM IN SUPPORT OF A DRUG-FREE WORKPLACE

1. Purpose. To implement fully an effective Employee Assistance Program (EAP) within (agency) which provides short term counseling and referral services to employees with drug problems. This is in keeping with the President's policy, set forth in Executive Order 12564, to eliminate drug use from the Federal workplace and to offer an opportunity for rehabilitation to users of illegal drugs. This model is intended to supplement ongoing employee assistance programs which, in addition to drug abuse, address alcohol abuse and other employee problems.

2. Background. Public Law 92-255, as amended, requires Federal agencies to develop and maintain appropriate prevention, treatment and rehabilitation programs and services for drug abuse among Federal employees. Regulations implementing this requirement are contained in Title 5, Code of Federal Regulations (CFR) Part 792. Guidance is further provided in Subchapters 5 and 6 of Federal Personnel Manual (FPM) Chapter 792, and FPM Supplement 792-2. Executive Order 12564 of September 15, 1986, established further requirements for agencies and employees in order to obtain a drug-free Federal Workplace. On October 27, 1986, the President signed into law the Omnibus Drug Enforcement, Education, and Control Act of 1986, P.L. 99-570. That law reiterates Congressional concern about the prevention of illegal drug use and the treatment of Federal employees who use drugs.

3. Objective. The objective of the EAP is to assist employees with drug problems to find treatment, to follow up with them during recovery and rehabilitation, and to help them remain drug-free.

4. Policy.

A. As an employer, the (agency) is concerned with the well-being of its employees, the maintenance of workforce productivity, and the preservation of a safe and secure workplace. The use of illegal drugs by (agency) employees, whether on or off the job, is inconsistent with these goals and will not be tolerated.

B. The (agency) stands ready to assist employees in becoming drug free.

C. Employees who are users of illegal drugs are encouraged to seek counseling and other appropriate assistance voluntarily, including that available through the (agency's) Employee Assistance Program.

D. The confidential nature of client records will be safeguarded and only disclosed in accordance with the confidentiality provisions of Title 42 CFR, Part 2.

E. To the extent feasible, program services will be provided to family members dealing with the drug problem of an employee, or to an employee dealing with the drug problem of a family member.

5. Program Responsibilities.

A. Agency Employee Assistance Program Administrator. The Employee Assistance Program Administrator has the lead role in ensuring that the (agency's) EAP program meets the requirements of E.O. 12564, and is responsible for the development, implementation and review of the agency EAP. In addition to supervising the headquarters EAP Coordinator and counselor(s), the Administrator will provide advice and assistance in establishing field office EAP's. The EAP Administrator will advise agency components on the submission of annual statistical reports and will prepare consolidated reports on the agency's EAP activity for submission to the Office of Personnel Management on a fiscal year basis.

B. Employee Assistance Program Coordinators.

(1) The Employee Assistance Program Coordinator has responsibility for implementing and operating the EAP within an agency component, such as the Headquarters office or a field installation. More than one coordinator may be deemed necessary, depending on the size of the assigned component. Where the EAP services are contracted out, the coordinator has responsibility for monitoring the contractor performance and verifying services rendered within (agency). The person(s) selected for such assignments will be allotted sufficient official time to:

(a) implement effectively the agency employee assistance policy and program as well as to assist in the development and implementation of the agency drug testing program as it relates to the counseling and rehabilitation of drug-abusing employees;

(b) determine appropriate supervisory training and other activities needed to educate and inform the workforce about drugs and symptoms of drug abuse;

(c) develop and maintain counseling capability (through personnel, medical, or other counseling resource, including contracting out);

(d) establish liaison with community education, treatment and rehabilitation facilities; and,

(e) evaluate the program and report to management on results and effectiveness.

C. Employee Assistance Counselors. (1) In some instances, the EAP Coordinator may have the necessary skills, time and motivation to function as the Employee Assistance Counselor. The Employee Assistance Counselor serves as the initial point of contact for employees who ask or are referred for counseling, and will be allotted sufficient official time to implement the program effectively. At a minimum, persons designated as Employee Assistance Counselors should be, or provisions should be made for them to be:

(a) Familiar with the provisions of Executive Order 12564, "Drug-Free Federal Workplace" and Federal Personnel Manual Letter 792-16, "Establishing a Drug-Free Federal Workplace".

(b) Trained in:

- counseling employees in the occupational setting,
- identification of drug abuse, and,
- administering the Employee Assistance Program.

(c) Able to communicate effectively with employees, supervisors and managers concerning drug use and its symptoms and consequences.

(d) Knowledgeable about community resources for treatment and rehabilitation of drug users, including information on fees and payment schedules.

(e) Able to discuss drug treatment and rehabilitation insurance coverage available to employees through the Federal Employee Health Benefits Program.

(f) Able to distinguish the occasional user from the addicted user and to suggest the appropriate treatment based on that information (e.g., after hours attendance at Narcotics Anonymous meetings to significant medical assistance).

(a) Able to provide training and education on drug abuse to employees, supervisors, union representatives, etc.

(2) In offices where counseling staff is not available within the agency, reasonable efforts should be made to provide employees with access to a qualified counselor outside of the agency. This may include authorizing official time for the employee to visit or be visited by a counselor personally, or other steps which may be appropriate.

(3) For employees referred as a result of drug-testing, counselors should document the treatment plan prescribed. Signature of this document by both the counselor and client will ensure mutual understanding of the treatment plan and the consequences of failure to remain drug free.

(4) In order for the counselor to be viewed as the source of assistance and understanding for employees, the person(s) performing these functions should not be involved in the actual drug testing of employees.

D. Employee's Role. All employees are encouraged to enhance their drug awareness through educational opportunities afforded by the EAP or the community at large. Employees who are illegal drug users are encouraged to seek counseling assistance voluntarily. Employees found to be users of illegal drugs are required to accept referral to the EAP and are urged to cooperate with medical treatment and/or rehabilitation programs that are indicated.

E. Medical Personnel.

(1) Employee health units provide emergency diagnoses and first treatment of injury or illness of employees during duty hours. Where indicated, the employee should be further referred to a private physician or community health service. If such cases ultimately are determined to have stemmed from abuse of drugs, medical personnel should discuss the facts of the situation with the supervisor and the employee and refer the employee for counseling. A close working relationship with the EAP Counselor(s) is essential for program success. The Health Unit staff is available for consultation with and assistance to personnel assigned EAP responsibilities.

(2) Where such facilities do not exist, these services are provided whenever possible through existing occupational health facilities and/or community physicians or clinics.

6. Training and Education.

A. Supervisory training. Employee counselors will conduct or otherwise provide training sessions for agency supervisors on the handling of problems of substance abuse. Appropriate topics include:

(1) Drug awareness and symptoms of drug use.

(2) Recommended methods for dealing with the suspected or identified drug user.

(3) Supervisory responsibilities under E.O. 12564.

(4) Confrontation and referral techniques.

(5) Explanation of the (agency) employee assistance program and its relationship with the (agency) drug testing program.

(6) General principles of rehabilitation including techniques for supervisors to assist employees in returning to the worksite, given specific (agency) needs and requirements.

(7) Personnel management issues (e.g., relationship of this program to performance appraisal and disciplinary programs; leave usage; and, supervisory notes and documentation).

B. Employee education. The Employee Assistance Coordinator will ensure that employee seminars on topics dealing with drug use are provided periodically. Managers and supervisors shall encourage employee attendance at these seminars and provide other appropriate support. On a continuing basis, educational materials and information on drug abuse will be available to individual employees.

7. Publicity of EAP to employees.

A. This policy and program will be made known to all (agency) employees. All new employees will be informed of the services available under this program as they enter on duty.

B. The names and locations of Employee Assistance Counselor(s) should be listed in telephone directories and displayed on employee bulletin boards.

C. Periodic employee memoranda and other appropriate publications should be used to keep employees informed of EAP services.

8. Short-term Counseling and Referral.

A. Referrals to the Employee Assistance Program are for the purposes of identifying the problem, referring the employee to the appropriate treatment resource in the community and following up with the employee during recovery and rehabilitation.

B. Voluntary referrals, or self referrals, are to be encouraged throughout EAP materials.

C. In the case of a management referral as a result of a positive drug screen, the employee assistance staff will interview and/or consult with supervisors and management officials, as requested, and provide them with guidance on how to refer the drug abusing employee to the assistance program. Once the referral is made, and the employee agrees to the appointment with the counselor, the counselor will require the employee to sign a consent for release of information to the supervisor before assistance will be provided. This consent will cover the release of information pertaining to the employee's compliance with the agreed upon treatment plan and the employee's progress during and at the end of treatment. Upon obtaining the signed consent, the counselor will assess the problem(s), review the employee's health insurance coverage and refer the individual to an appropriate treatment resource in the Community. The counselor will monitor the employee's treatment and keep the supervisor advised as to the progress being made. The counselor will periodically follow-up with the employee and his or her supervisor after any treatment which occurs and offer support and assistance as needed.

9. Community Resources. The EAP will develop a working relationship with community assistance resources. Program coordinators and counselors will determine which community agencies or individuals best meet employee and management needs. Contact should be established with specialized resources such as the following:

A. State drug authorities for help in identifying treatment resources for drug abusing employees;

B. Narcotics Anonymous for information on where and when meetings are held;

C. Hospital and clinic treatment facilities in order to establish a working relationship between the counselor and the receiving treatment source; and,

D. Drug abuse councils to keep abreast of the latest development regarding drug abuse.

10. Program Interrelationships.

A. Relationship with Drug Testing Program. As called upon, the EAP staff will work with the drug testing program staff in the development and implementation of the drug testing program. However, EAP staff are not to be involved in the collection of urine samples or the initial reporting of drug test results. EAP efforts are to focus on counseling and rehabilitating drug-abusing employees, as well as on educating the workforce regarding drug abuse and its symptoms.

B. Relationship of the Supervisor. Supervisors have explicit expectations of their employees in terms of job performance and behavior. When supervisors are advised of confirmed employee drug use, they are required to refer the employee to an Employee Assistance Program and to initiate an appropriate personnel action. In those situations involving illegal drugs, except as provided in Section 5(b) of Executive Order 12564, disciplinary action is required to be initiated against employees who are found to use illegal drugs. Supervisors should work with the Employee Assistance Counselor to monitor the employee's progress during treatment and rehabilitation and take appropriate personnel action should the employee fail to remain drug free.

C. Relationship with Labor Organizations. The support and active participation of labor organizations is a key element in the success of an employee assistance program. Therefore, where there are units of exclusive recognition, management should:

(1) Communicate to labor organizations a strong commitment to providing assistance to employees.

(2) Consult or negotiate, as appropriate, concerning the implementation of the EAP.

(3) Include union representatives in appropriate training and orientation programs to ensure a mutual understanding of program policy, referral procedures, and other program elements.

11. Recordkeeping and Reporting.

A. Counseling Records. Records on employees who have been referred for counseling will be maintained in a secure and confidential manner. Information on any drug abuse client will be released only to the management official empowered to recommend or take action, in accordance with the employee's consent to release, and for the reasons identified in section 8C above. Any information obtained by a supervisor from the counselor must be maintained, as with all employee records, in a strictly confidential manner. In addition, to the extent that

counseling records include employee treatment records, they shall be maintained in accordance with Public Law 93-579 (Privacy Act), Public Law 93-282 and Title 42 CFR, Part 2 (Confidentiality of Client Records). Consequently, access to these records will be strictly limited. All appropriate steps, including necessary physical safeguards, will be taken to ensure against unauthorized disclosure.

B. Reports to OPM. The EAP Administrator will compile sufficient statistical and programmatic data to provide the basis for evaluating the extent of drug abuse problems and effectiveness of the assistance program. The EAP Administrator will also submit agency-wide reports to the Office of Personnel Management that contain data required by OPM to meet the statutory reporting requirements contained in P.L. 99-570.

12. Program Evaluation. The EAP Administrator and Coordinators will regularly evaluate their program to determine the effectiveness and efficiency of services. These evaluations will include: services to employees with drug abuse problems, referral procedures and effectiveness, supervisory training, employee orientation, reporting systems, availability and accessibility of EAP, records systems, outreach activities, staffing and qualifications procedures. Written evidence of program evaluations, identified deficiencies and correction plans will be available for review by the EAP Administrator. Documented modifications in the program's assessment and intervention services should be made based upon the findings of such evaluations.

APPENDIX C

FPM Letter 792-17 of March 9, 1987

Federal Personnel Manual System

FPM Letter 792-17

Published in advance of incorporation in FPM Supp. 792-2
RETAIN UNTIL SUPERSEDED

SUBJECT: Establishing a Drug-Free Federal Workplace

Washington, D. C. 20415
March 9, 1987

Heads of Departments and Independent Establishments:

1. The purpose of this letter is to amend the guidelines published by this agency on November 28, 1986, in Federal Personnel Manual (FPM) letter 792-16, with regard to the confidentiality of drug test results. The following portion of the guidelines supersedes the corresponding portion of FPM letter 792-16. Both of these FPM letters will be incorporated into FPM Supplement 792-2 which is scheduled for release in the near future.

2. The amendment of the guidelines was warranted by the recent issuance of technical and scientific guidelines on drug testing by the Department of Health and Human Services. These amendments clarify the parameters of the confidentiality protection to be afforded drug test results under Executive Order 12564, a Drug-Free Federal Workplace, issued on September 15, 1986. It should also be noted that the Office of Personnel Management will soon issue amendments to several government-wide systems of records notices required under the provisions of the Privacy Act, 5 U.S.C. § 552a, et seq.

3. Subparagraphs (5), (6), and (7) of Section 4f of FPM Letter 792-16, are replaced by the following subparagraphs, which include the amendments:

(5) Accordingly, drug abuse treatment or rehabilitation records may not be otherwise disclosed by agencies without the consent of the employee involved. A sample consent for release of patient information during and after treatment or rehabilitation and a sample release memorandum are included in attachments 2 and 3, respectively. Any disclosure without such consent is strictly prohibited.

(6) As part of the drug testing procedure, confirmed positive test results should only be released to the agency's medical review official (as defined in the HHS guidelines), the administrator of the agency Employee Assistant Program (EAP), and to the management official empowered to recommend or take action.

(7) After examination by the medical review official, confirmed positive test results will be forwarded to the agency EAP program administrator and to the management official empowered to recommend or take action. Drug test results will be protected under the provisions of the Privacy Act, 5 U.S.C. § 552a, et seq., and may not be released in violation of that Act. Records of unconfirmed positive test results and negative test results will be destroyed by the laboratory.

Constance Horner
Director

Inquiries: Office of the General Counsel, (202) 632-4632

Code: 792, Federal Employees' Health and Counseling Programs

Distribution: Basic FPM, FPM Supplement 792-2

*U.S. GOVERNMENT PRINTING OFFICE: 1987-180-590:2741

APPENDIX D

42 CFR, Part 2

Federal Register

Tuesday
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 arising 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 permitted 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 include 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 empolyees 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

Public Both the existing and proposed rules provide for the reporting of any violations of the regulations to the Con. Abus. 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 necessary 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 Permits Reporting of Child Abuse and Neglect

Section 106 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. [illegible] 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

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)(15)(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 with 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 program, 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 [illegible] methadone maintenance treatment (see 21 CFR [illegible]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' Administration 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) [illegible] 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) *Restriction on disclosure [illegible] third party payers, [illegible] administrative [illegible] 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

[redacted] 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 [redacted] 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, [redacted]ment, or referral is provided may be [redacted]owledged only if the patient's [redacted]ten consent is obtained in accordance with subpart C of these regulations or if an authorizing court order is entered in accordance with Subpart [redacted] regulations permit [redacted] 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 [redacted]

(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

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 his 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 enrollment 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 a 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 a 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 § 2.65 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 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 employer of patients 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.

[FR Doc. 87-11785 Filed 6-8-87; 8:45 am]

BILLING CODE 4160-17-M

APPENDIX E

Consent for Release of Confidential Information Form

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

EMPLOYEE ASSISTANCE PROGRAM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

1. NAME: _____

2. I do hereby authorize _____, Coordinator, Employee Assistance Program to disclose to _____
(Name of person, organization or program)

3. the following information _____
(Extent and/or Nature of Information)

4. for the purpose of _____
(Purpose or need for disclosure)

I understand that my records are protected under the Privacy Act of 1974 and the Federal Civilian Employee Alcoholism and Drug Abuse Confidentiality of Records (42 CFR). I understand that information about me cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on this informed consent. I understand that even if I do not withdraw the consent that this statement of consent shall automatically expire on:

5. _____
(Specify date or circumstances under which consent will expire)

6. Executed on the _____ (Day) of _____ (Month), 19 _____ (Year).

_____
(Signature of Employee)

_____
(Signature of Employee Assistance Program Coordinator)