Position Statement on the Role of Confidentiality in Volunteer Military Drug Abuse Treatment Programs

This statement was approved by the Board of Trustees of the American Psychiatric Association at its December 14-15, 1974, meeting upon recommendation of the Council on Professions and Associations. It was prepared by the Task Force on Confidentiality as It Relates to Third Parties.¹

The American Psychiatric Association was much encouraged and pleased when the President and the Department of Defense adopted a policy of viewing the drug abuser as a medical problem, while still maintaining its efforts to eradicate the traffic in drugs. A treatment program written by the military establishment must be seen as positive action directed toward furthering the primary mission of the armed forces.

The role of confidentiality in successful psychiatric treatment has been well established. The development of a positive treatment atmosphere for a voluntary rehabilitation program for drug abusers is partially contingent upon the degree to which a psychiatrist can assure the patient of the confidentiality of his disclosures. The real or threatened adverse consequences of disclosure may cause personnel to avoid seeking treatment altogether or not to cooperate fully in the treatment regime.

As civilian psychiatrists, we can only recommend those things concerning confidentiality that we feel will help lead to an effective voluntary military drug abuse treatment program. In any program offering confidentiality, the limits of confidentiality must be defined. Any promise of nonpunitive action must truly be nonpunitive; otherwise, the subsequent disillusionment of the treated person will create a destructive reaction to both his treatment and the program in general. There have been examples of unsuccessful treatment programs where the limits of confidentiality were not well defined and, indeed, did not prevent the occurrence of secondary punitive action. Protection for those honestly seeking help will provide a more effective program and increase the motivation for help.

The act of volunteering should grant protection only for a confidential evaluation prior to the volunteer’s acceptance into the drug abuse treatment program and for ongoing participation and cooperation in the program. In recommending this amnesty, we do not imply that personnel in treatment are immune from the consequences of unacceptable behavior secondary to or not related to the fact of treatment.

Being labeled a drug abuser is punitive in itself. For that reason, as far as possible all medical records relating to treatment should be held inviolate in the medical treatment sector. In military programs as in civilian programs, both the patient and psychiatrist recognize that, at various times and for various reasons, this confidentiality cannot be absolute. The medical unit and the command unit must be aware of each other’s needs and responsibilities and must keep each other adequately informed of factors that would represent a hazard to the treatment of the individual or to the command’s mission. (Army regulation AR-40-42 is an example of these safeguards.)

Three special considerations that have been brought to our attention could also seriously and adversely affect the viability of drug abuse treatment programs.

1. Compromising conditions for entering the treatment program should be avoided. For example, making amnesty or treatment conditional on the individual’s becoming an informer will seriously affect the credibility of the program. (The Army has taken note of this in Army regulation AR-40-42, paragraph 6G, which specifically deals with this point.)

2. There have been reports of damaging breaches of the patient’s confidentiality by the release of critical information to civilian sources after the individual’s discharge from military duty. One way of exposing individuals who have been in drug treatment programs after their separation from service has been the SPN number on discharge papers. We would urge reexamination of the policy of using these SPN numbers on discharge records that are not kept in confidential medical files.

3. There has been an intermingling of an individual’s general personnel records and his medical records at the National Personnel Record Center after his separation from service. The medical records have been made available for other than military uses after personnel have returned to civilian life. To protect confidential information we recommend an exploration of methods to separate from the personnel records the medical records and references to medical diagnoses.

We are pleased that the Department of Defense is already considering the problem of confidentiality, and we hope these comments will be of use in the implementation of its programs.

¹The Task Force on Confidentiality as It Relates to Third Parties included: Maurice Grossman, M.D., chairman, Richard G. Johnson, M.D., Joseph Satten, M.D., Jack D. Barchas, M.D., and Alan L. Krueger, M.D.