

**COMMONWEALTH OF VIRGINIA  
COMMISSION ON MENTAL HEALTH LAW REFORM**

**FINAL INTERIM  
REPORT AND RECOMMENDATIONS**

**OF THE**

**WORKING GROUP ON HEALTH PRIVACY AND THE CIVIL COMMITMENT PROCESS**

**December 26, 2007**

**I. INTRODUCTION**

As part of the Commonwealth of Virginia Commission on Mental Health Law Reform's comprehensive examination of Virginia's mental health laws, Chairman Richard J. Bonnie appointed a special working group to study the relationship between health privacy laws and the civil commitment process - the Working Group on Health Privacy and the Civil Commitment Process ("Working Group"). The membership of the Working Group is attached as Attachment 1.

The charge of the Working Group was as follows:

To recommend any changes necessary or desirable to balance the often competing goals of facilitating the maximum availability of relevant clinical information to help all participants in the commitment process make informed decisions, while assuring that the privacy of the patient's personal health information is fully protected as required under the HIPAA Privacy Rule.

Consistent with the charge, the Working Group carefully examined Virginia and federal law governing allowable disclosures and the sharing of health care information by and between participants in the context of the commitment process. Our work concentrated on addressing the following questions and issues:

- A. Under current law, can a Community Services Board ("CSB") Pre-Screener and an Independent Examiner obtain confidential health care information from a health care provider concerning a person who may have mental illness and who is the subject of a commitment process, without that person's authorization? Is statutory change or clarification necessary or desirable?
- B. Under current law, can a Pre-Screener and Independent Examiner disclose confidential health care information within the Virginia judicial process created to assess the need for mental health treatment? Is statutory change or clarification necessary or desirable?

- C. What health care information that would otherwise be confidential is available to the public as a result of a commitment hearing? What health care information should be publicly available? Is statutory change or clarification necessary or desirable?

## II. BACKGROUND

In the mental health commitment context, issues surrounding the disclosure of health care records without the authorization of the subject of the records arise in three scenarios:

- (a) when a provider is contacted by a Pre-Screener, on behalf of the CSB, during a four hour emergency custody order window to obtain medical information;
- (b) when a health care provider is contacted by an Independent Examiner pursuant to a temporary detention order to obtain medical information that would facilitate assessment of the person's mental health, stability and need for judicially ordered involuntary treatment; and
- (c) when the CSB or Independent Examiner provides health care information to the magistrate to allow the process to move forward for determination of whether a temporary detention order is appropriate and subsequently to a circuit court judge, district court judge or special justice to determine whether involuntary treatment is appropriate.

These scenarios are governed by two sets of laws. In Virginia, healthcare providers are governed by the Health Records Privacy Act (the "Act"), Va. Code § 32.1-127.1:03;<sup>1</sup> they are also governed by the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d, *et seq.*) ("HIPAA"). The regulatory structure implementing HIPAA with respect to the use and disclosure of Protected Health Information ("PHI") is the HIPAA Privacy Rule, 45 CFR § 164.500, *et seq.* A provider who falls within HIPAA's coverage definition is a Covered Entity ("CE").<sup>2</sup> The Act, HIPAA and HIPAA's Privacy Rule define a health care provider, and dictate what a health care provider may disclose and to whom.

The Act became effective in the latter half of the 1990's. HIPAA became effective on April 14, 2003, and had been in place for four years before the tragic incident at Virginia Tech. At this point in time, the Working Group has been told there is no known problem of a health care provider declining to provide medical information in the course of the mental health commitment process.

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<sup>1</sup> Except where specifically provided in the Act, the Act does not apply to the health records of a minor. Va. Code § 32.1-127.1:03(C)(2).

<sup>2</sup> A provider is a Covered Entity if it engages in electronic transactions as defined in HIPAA. Except for some providers who are not now billing electronically and who are not billing Medicare, most health care providers are Covered Entities.

Virginia's experience with the Act is also noteworthy. Historically, disclosure under the Act is presumptively permissive – a disclosure is mandatory only if it is required by another provision of the Va. Code. For some time, and pre-dating HIPAA, the Act authorized, but did not require, health care providers to disclose to the attorney representing a person in a civil commitment proceeding the health records of the person. The fact that such disclosure was permitted, but was not mandatory, under Virginia law created a conflict when HIPAA became effective in 2003 - HIPAA authorizes disclosure in this area only if the disclosure is “required” by state law.

The General Assembly acted quickly to resolve the conflict in favor of mandatory disclosure in the civil commitment context. In 2004, Va. Code § 37.2-814(E), part of the commitment statutes, was amended to require health care providers to disclose to the attorney representing a person whose involuntary admission is sought all diagnostic and other reports, treatment information and records concerning his client. In addition, the existing language in the Act [§ 32.1-127.1:03(D)(12)] that authorized providers to disclose medical records to lawyers representing the patient without the patient's authorization was refined. In essence, health care providers are instructed under § 32.1-127.1:03(D)(12) that they must disclose to counsel the health information of a person involved in the commitment context in accordance with the mandate of § 37.2-814(E).

This historical perspective, and the need to mandate disclosure to be HIPAA-compliant, is very important, as will be evidenced below in Section III.B.3 of this Report.

### **III. ISSUES AND ANALYSES**

- A. Under current law, can a Community Services Board (“CSB”) Pre-Screener and an Independent Examiner obtain confidential health care information from a health care provider concerning a person who may have mental illness and who is the subject of a commitment process, without that person's authorization? Is statutory change or clarification necessary or desirable?**

Healthcare providers that are CEs are governed by HIPAA, which controls the disclosure of PHI. HIPAA preempts contrary state law, unless the contrary state law is more restrictive, *i.e.*, unless the state law is more protective of patient confidentiality. Thus, any analysis should begin with an examination of HIPAA's Privacy Rule (45 CFR § 164.500, *et seq.*).

**1. HIPAA permits a CE to disclose PHI to a Pre-Screener.**

45 CFR § 164.502(a)(ii) provides that “a covered entity is permitted to use or disclose protected health information . . . [f]or treatment . . . as permitted by and in compliance with [45 CFR] § 164.506.

45 CFR § 164.506(c)(2) provides that “a covered entity may disclose protected health information for treatment activities of a healthcare provider,” in addition to using or disclosing

PHI for its own purposes of providing treatment. (Hereafter, this will be referred to as the “HIPAA treatment exception”).

45 CFR § 164.501 defines “Treatment” to mean “the provision, coordination, or management of health care *and related services* by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to patient; or the referral of a patient for health care from one health care provider to another.” (Emphasis added)

In the Working Group’s view, the Pre-Screener’s assessment activity is treatment through the coordination of services related to health care, consistent with 45 CFR § 164.501.

The Pre-Screener is also a health care provider, consistent with 45 CFR § 164.506(c)(2), under two theories: (i) a Pre-Screener under Virginia law is a person who is an employee or a designee of the Community Services Board [Va. Code § 37.2-808(B)], and a Community Services Board is a health care provider under the definition applicable to HIPAA in 45 CFR § 160.103;<sup>3</sup> (ii) by statute, the Pre-Screener, whether an employee or designee of the CSB, has to be skilled in the diagnosis and treatment of mental illness; such a person, when pre-screening on behalf of a CSB, would appear to meet the definition of “Health care provider” in 45 CFR § 160.103.

Importantly, comment accompanying the publication of the Final HIPAA Privacy Rule in August, 2002, states HIPAA’s clear policy of allowing the free flow of information for treatment purposes:

For treatment purposes, the Rule generally allows protected health information to be shared without restriction. The definition of “treatment” incorporates the necessary interaction of more than one entity. . . . As a result, covered entities are permitted to disclose protected health information for treatment purposes regardless of to whom the disclosure is made, as well as to disclose protected health information for the treatment activities of another healthcare provider.

67 Fed. Reg. 53214.<sup>4</sup>

In sum, both by definition and policy under HIPAA, a CSB Pre-Screener is a health care provider who is coordinating a person’s mental health treatment, and can obtain confidential health care information from another health care provider without the permission of the subject of the health care information.

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<sup>3</sup> “Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395 x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.” 45 CFR § 160.103.

<sup>4</sup> Both HIPAA and the Act give heightened protection to disclosure of psychotherapy notes. Health care providers may not disclose psychotherapy notes as defined by HIPAA and the Act (both have the same definition) unless meeting one of the few exceptions HIPAA and the Act provide.

**2. The Act permits disclosure to a Pre-Screener.**

The Act broadly prohibits disclosure of an individual's health records [Va. Code § 32.1-127.1:03(A)], but specifically provides that "Health care entities may . . . disclose health records . . . [w]here necessary in connection with the care of the individual." Va. Code § 32.1-127.1:03(D)(7).

Clearly, in the context of a mental health commitment, where an individual may pose a danger to himself or others or be so seriously mentally ill as to be substantially unable to care for himself, disclosure of the individual's health records is necessary in connection with the individual's care.

**3. Both HIPAA and the Act permit disclosure to the Independent Examiner.**

Prior to a commitment hearing for involuntary admission, the subject of the hearing must be examined by an Independent Examiner. Va. Code § 37.2-815.<sup>5</sup> At a minimum, the Independent Examiner must be a mental health professional who is licensed through the Virginia Department of Health Professions and who is qualified in the diagnosis of mental illness. *Id.* Accordingly, an Independent Examiner is clearly a health care provider under both HIPAA<sup>6</sup> and the Act.<sup>7</sup>

**4. Impediments to Disclosure.**

**a. Family Educational Rights and Privacy Act.**

Records held by educational institutions may not be available for use in the commitment hearing process. This may limit attempts by Pre-Screeners or Independent Examiners to access records of previous treatment, as well as the ability of the local CSB to determine whether a student ordered into outpatient treatment is complying with the order. These potential restrictions arise from the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) ("FERPA"). The regulatory structure implementing FERPA is found at 34 CFR § 99.1 *et*

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<sup>5</sup> See also, Va. Code § 16.1-342 with respect to evaluations in the juvenile commitment process. The evaluation is performed by a "Qualified Evaluator," which is the equivalent of an Independent Examiner in Title 37.2. References in this Report to Independent Examiners include Qualified Evaluators.

<sup>6</sup> "Health care provider means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395 x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business." 45 CFR § 160.103.

<sup>7</sup> " 'Health care provider' means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multi-state licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine." Va. Code § 32.1-127.1:03.

*seq.* FERPA is aimed at ensuring the privacy of student records, and generally requires that records may not be disclosed outside the educational institution.

The release of records stored at university counseling centers or other campus health center is governed by FERPA.<sup>8</sup> FERPA, since it is written for educational records, does not have a disclosure exception for treatment of an individual as is found in medical records privacy rules such as HIPAA and the Act. Also unlike HIPAA, FERPA does not have an exception that allows disclosure if such disclosure is required by state law.<sup>9</sup>

For a Pre-Screener or Independent Examiner, the only FERPA exception that might apply is the emergency exception, which allows disclosure of information to “appropriate persons,” “in connection with an emergency,” if “such information is necessary to protect the health or safety of the student or other persons.” *See* 20 U.S.C. § 1232g(b)(1)(I). However, the regulations implementing the law warn that this exception is to be “strictly construed.” *See* 34 CFR § 99.36(c). Even if this standard is met, the school would only be allowed, not required, to share information. Accordingly, Pre-Screeners and Independent Examiners might find it difficult to convince a university that such information can be shared.<sup>10</sup> Given these concerns, the emergency exception should not be relied on as a method of gaining documents protected by FERPA.

CSBs could face similar problems in attempting to check the compliance of individuals ordered into outpatient treatment at school counseling centers. Here, unless the emergency exception applied, the only way a CSB could obtain the records would be pursuant to a court order. *See* 34 CFR § 99.31(a)(9)(i).

For the time being, records held at educational institutions may not be available to the commitment process. Ultimate resolution of the issue would require a change in federal law, and the Working Group recommends that the Commission urge efforts to be made in this direction. In the interim, the Working Group suggests that both those involved in the commitment process and the educational field consider the use of the emergency exception where appropriate. In addition, the Working Group suggests that judges or special justices consider the potential FERPA challenges before ordering an individual into counseling in a school setting. This may bear on whether a CSB can monitor treatment, which is a finding the special justice must make before ordering outpatient treatment. *See* Va. Code § 37.2-817(C)(4). Also, a judge or special justice should be mindful that a university counseling center may only accept patients who

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<sup>8</sup> Technically, while they are stored at the counseling center or health center, they are exempted from FERPA. *See* 20 U.S.C. 1232g(a)(4)(B)(iv). However, the Department of Education, which interprets FERPA, has indicated that when the information moves outside of the counseling center, FERPA protections apply. *See* Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, November 29, 2004 at pg. 3.

<sup>9</sup> *See* Section III.B.3 of this Report.

<sup>10</sup> The Department of Education has ruled that a disclosure made to a court for a student who threatened another student, played with knives in class, and spoke of suicide was a valid disclosure under the emergency exception. *See* Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Superintendent, New Bremen Local Schools, September 24, 1994 at pg. 3. Therefore, in some cases, Pre-Screeners might be able to successfully argue that the exception applies.

voluntarily come for treatment. If a judge or special justice feels that counseling in a school setting would be appropriate, he or she should take steps to remedy the potential challenges. For example, a judge or special justice could require the individual (or parent) to execute a FERPA waiver<sup>11</sup> before ordering such treatment.<sup>12</sup> Together, these recommendations can somewhat alleviate the potential difficulties posed by FERPA.

**b. 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.**

42 U.S.C. § 290dd-2 is a federal statute that generally prohibits the disclosure and use of alcohol and drug abuse patient information:

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 substance abuse education, prevention, training, treatment, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall . . . be confidential and be disclosed only for the purposes and under the circumstances expressly authorized . . . . 42 U.S.C. § 290dd-2(a).

The regulatory structure implementing this statute is found at 42 C.F.R. Part 2 (§§ 2.1 – 2.67).

The general rule under the statute and regulation is that the restrictions on disclosure apply to any information, whether or not recorded, that would identify a patient as an alcohol or substance abuser, either directly, by reference to other publicly available information, or through the verification of such an identification by another person, and is substance abuse information obtained by a federally assisted substance abuse program. 42 C.F.R. § 2.12(a)(1).

While the statute and regulations are very broad in their coverage, there are definitions and exceptions that tend to reduce their reach insofar as the involuntary commitment process is concerned.

Initially, the statute is applicable only to a federally assisted “program,” which is defined as an “individual or entity (other than a general medical care facility<sup>13</sup>) who holds itself out as

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<sup>11</sup> Parents are the appropriate persons to execute such a release if a student is under 18, unless the student is already attending a post-secondary institution. The consent requirement transfers to students when they reach 18 or begin attending post-secondary institutions. *See* 20 U.S.C. § 1232g(d).

<sup>12</sup> Although an option, a waiver is not a panacea since a waiver can be revoked.

<sup>13</sup> “Program” also means:

(b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

(c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. (42 C.F.R. § 2.11).

providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment.” 42 C.F.R. § 2.11. A program is federally assisted if it receives federal funds of any kind, either directly or indirectly (including payment through federally funded insurance). 42 C.F.R. § 2.12(b). However, to be a “program” subject to the regulation, even if an individual or entity receives federal assistance, the individual or entity (i) must also hold itself out as a substance abuse provider and (ii) must have obtained the information “for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.”<sup>14</sup> 42 C.F.R. § 2.12(a)(1). Thus, if a provider does not hold himself out as a substance abuse provider, or does hold himself out as such but obtains substance abuse information while treating a patient for reasons unrelated to substance abuse, the substance abuse information is not covered by the statute.

In the context of a commitment hearing, therefore, the statute is a potential impediment to disclosure only to the extent that substance abuse information related to the subject was obtained by a provider (who holds himself out as a substance abuse provider) for the purpose of treating the subject’s substance abuse, making a diagnosis for treating the subject’s substance abuse, or making a referral for the subject’s substance abuse. If a provider obtains substance abuse information, but did not obtain it for the purpose of treating, diagnosing or referring for substance abuse treatment, neither the provider nor the substance abuse information is covered by the statute.

Thus, the statute would potentially apply only to that subset of commitments in which the subject’s substance abuse generated the commitment petition. If the circumstances of the commitment fall within the statute’s disclosure prohibitions, the regulation provides an exception that could be applicable to commitments:

§ 2.51 Medical emergencies.

(a) General Rule. Under the procedures required by paragraph (c) of this section,<sup>15</sup> patient identifying information may be disclosed to medical personnel

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<sup>14</sup> The regulations provide this instructive example:

These regulations cover any information . . . about alcohol and drug abuse patients obtained by a program . . . if the program is federally assisted in any manner . . . . 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. However, these regulations would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of alcohol or drug abuse diagnosis, treatment or referral and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services. 42 C.F.R. § 2.12(e).

<sup>15</sup> 42 C.F.R. § 2.51(c) provides:

(c) Procedures. Immediately following disclosure, the program shall document the disclosure in the patient’s records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;



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.

The standard for disclosure (“immediate threat to the health of any individual and which requires immediate medical intervention”) is consistent with one of the two findings that a judge or special justice may make for an involuntary commitment in Virginia – that the subject presents an imminent danger to himself or others. It is likely not consistent, however, with the second finding that could be made – that the subject is so seriously mentally ill as to be substantially unable to care for himself.

Additionally, the phrase “medical personnel” is not defined in the statute or the regulation. While the Working Group believes, as discussed earlier, that a Pre-Screener is a health care provider as defined by HIPAA, it is at least open to question whether a Pre-Screener can fall within “medical personnel,” since the phrase appears to be more focused and limiting than “health care provider.”

For these reasons, the medical emergency exception should not be relied on as a consistent way to obtain otherwise protected substance abuse information, although it could be used in appropriate circumstances where the issue is whether the subject presents an imminent danger.

In sum, this Federal statute could prohibit disclosure in those situations in which commitments are based on substance abuse and the subject is examined by a provider who holds himself out as a substance abuse provider. And the Federal statute preempts state law to the extent that state law authorizes or compels any disclosure that is prohibited by the Federal law. 42 C.F.R. § 2.20.

The regulation does permit disclosure with the subject’s written consent, but given the nature of the proceeding, consent is not a viable option. The regulation also authorizes disclosure if ordered by a court, but the requirements for obtaining an order are many, making this avenue simply not a viable option given the very limited time frame for commitment proceedings. 42 C.F.R. §§ 2.61 – 2.64.

As with FERPA, the ultimate resolution of this issue requires a change in federal law, and the Working Group recommends that the Commission urge efforts to be made in that direction.

## **5. Conclusions and Recommendations.**

The unanimous conclusion of the Working Group is that Pre-Screeners and Independent Examiners are health care providers.

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- (2) The name of the individual making the disclosure;
  - (3) The date and time of the disclosure; and
  - (4) The nature of the emergency . . . .

Nevertheless, the Working Group considered whether there may be a lack of clarity for practitioners and, thus, whether statutory amendments<sup>16</sup> would serve a useful purpose. Any lack of clarity may stem from the paradigm used to analyze the commitment process – are Pre-Screeners and Independent Examiners providers involved in the *treatment* process, or are they gathering information and performing evaluations for a *judicial* process? Both are trained and perform as health care providers in the continuum of the treatment process, but both are also doing so within the mandates and confines of the judicial process. Indeed, the necessary treatment is, in many cases, made available only as a result of the judicial process.

For several reasons, the Working Group concluded that amendments were not necessary and could actually be detrimental. First, there is unanimous agreement that Pre-Screeners and Independent Examiners are health care providers and there is no need to clarify this in the Code with respect to information sharing.

Secondly, in discussions of the Commission’s Task Forces and Subcommittees, there have been no issues raised with respect to the ability of the Pre-Screeners and Independent Examiners to obtain information. Rather, the constraints on them are more related to not having enough time to obtain the information.

Thirdly, since Pre-Screeners and Independent Examiners are health care providers, amending the Code to specifically define them as what they already are lessens their status, and still leaves ambiguity about whether they are functioning within a treatment process or a judicial process.

Finally, and probably most importantly, the determination of whether commitment falls within a treatment model or a judicial model is not necessary to permit the sharing of information. The two models are inseparable in the commitment context and, for the Working Group’s purposes, any such characterization would be artificial.

Consequently, the Working Group does not believe that any statutory changes or clarifications are either necessary or desirable to specify that Pre-Screeners and Independent Examiners are health care providers in the commitment context.<sup>17</sup>

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<sup>16</sup> For example, specifically including Pre-Screeners and Independent Examiners within the definition of “Health care provider.”

<sup>17</sup> The Working Group does recommend statutory changes that include a requirement that health care providers disclose health information to Pre-Screeners and Independent Examiners. See Sections III.B.2. and 3. of this Report.

**B. Under current law, can a Pre-Screener and Independent Examiner disclose confidential health care information within the Virginia judicial process created to assess the need for mental health treatment? Is statutory change or clarification necessary or desirable?**

**1. HIPAA may permit disclosure to a Judge or Special Justice, but it is unclear.**

As a policy matter, it would not make any sense that a Pre-Screener and an Independent Examiner could not disclose the results of their medical screening and evaluation to the judicial authority for which they are performing the screening pursuant to a statutorily created judicial process. Nevertheless, HIPAA is not clear on this issue and HIPAA resources do not appear to address it.

The Working Group examined HIPAA to see if such disclosures could possibly fall within any of several exceptions. It first looked at the HIPAA treatment exception, but concluded that extension of this exception to the judicial phase of the commitment process – *i.e.*, to a judge or special justice – was stretching the exception too far beyond its intended purpose.

The Working Group also reviewed two of the exceptions for disclosures for law enforcement purposes - 45 CFR §§ 164.512(f)(1)(ii)(A) and (C). These exceptions permit a CE to disclose PHI “for a law enforcement purpose to a law enforcement official . . .

(i) as required by law . . . [45 CFR § 164.512(f)(1)(i)]; or

(ii) in compliance with . . .

[a] court order or court-ordered warrant, or subpoena or summons issued by a judicial officer [45 CFR § 164.512(f)(1)(ii)(A)]; or

[a]n administrative request, including an administrative subpoena or summons . . . [45 CFR § 164.512(f)(1)(ii)(C)].”

These exceptions require that the disclosure be to a “law enforcement official.” Thus, one of the important issues raised by the exceptions is whether persons working within the judicial system created for commitment determinations can be considered “law enforcement officials,” defined by HIPAA as follows:

“Law enforcement official” means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to: (1) Investigate or conduct an official inquiry into a potential violation of law; or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law. (45 CFR § 164.501).

Presumably, not all situations within the commitment process involve alleged violations of law. Thus, it is unlikely that the law enforcement exceptions will routinely support disclosure to a district court judge or special justice in the commitment context.

In addition, Pre-Screeners and Independent Examiners must ordinarily conduct their work before any court order is issued, making it unlikely that such order could be used to help them.

Another potential basis under HIPAA for a permitted disclosure could be 45 CFR § 164.512(j)(1)(i)(A) and (B) and 45 CFR § 164.512(j)(4). Together, these regulations allow a disclosure in situations where the CE in good faith<sup>18</sup> believes that the use or disclosure “[i]s necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; . . . 45 CFR § 164.512(j)(1)(i)(A). Importantly, the “person” does not have to be a third party - the language does not exclude a threat to the health of the person himself.

This HIPAA exception clearly relates to a provider’s “duty to warn,” but the language is broad enough that the scenarios involving an involuntary commitment process could arguably fall within them. That result, however, is far from clear.

Ultimately, the Working Group concluded that it was very difficult to use any of the above HIPAA exceptions as authority for disclosure within the judicial commitment process.

## **2. The Commitment Statutes and the Act likely permit disclosure to a Judge or Special Justice.**

There is only one person involved in the court proceedings who is explicitly authorized to receive information - the counsel for the subject of the hearing. As discussed above (Section II), the Act authorizes, and Va. Code § 37.2-814(E) was amended to require, health care providers to share information with defense counsel. When HIPAA became effective, Virginia had to require the sharing of information to comply with HIPAA’s exception that permits disclosure when the disclosure is “required by law.”

There is no comparable specific mandate with respect to disclosures of health information to a judge or special justice. It can be fairly implied from the Virginia statutes, however, that health information is to be shared with a judge or special justice as part of a commitment hearing.

While Va. Code § 37.2-815 provides that the judge or special justice “shall require an examination of the person who is the subject of the hearing by a psychiatrist or a psychologist” and “shall summons the examiner,” the examiner is required only to “certify that he has personally examined the person and has probable cause to believe that the person (i) does or does not present an imminent danger to himself or others as a result of mental illness or is or is not so seriously mentally ill as to be substantially unable to care for himself and (ii) requires or does not

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<sup>18</sup> 45 CFR § 164.512(j)4 creates a presumption of good faith.

require involuntary inpatient treatment.”<sup>19</sup> The statute does not say anything about providing health information - rather, the Independent Examiner must only certify that an examination occurred and provide an opinion regarding the requirements for involuntary commitment.

Similarly, under the Act, Va. Code § 32.1-127.1:03(D)(10) authorizes disclosure “[w]hen examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order.” However, the Working Group was advised that examination and evaluation are not undertaken pursuant to judicial order. There is no order entered by the judge requiring evaluation/examination by the Pre-Screener or the Independent Examiner. Rather, the evaluation and examination are performed by operation of statute. Moreover, in many Virginia jurisdictions, Pre-Screeners and Independent Examiners do not attend commitment hearings<sup>20</sup> and, given the time limits involved, it might be impractical for a judge or special justice to obtain information through a court order.

Va. Code § 32.1-127.1:03(D)(6) authorizes the disclosure of health information “[a]s required or authorized by law relating to . . . serious threats to health or safety . . . .” But, the commitment statutes themselves do not explicitly authorize sharing of health information (*i.e.*, the disclosure of health information is not “authorized by law”), so it is questionable whether this provision supports the necessary disclosure authority.

The clearest provision under Virginia law authorizing the disclosure of health information to a judge or special justice is the following exception provided by the Act: “Health care entities may . . . disclose health records . . . [w]here necessary in connection with the care of the individual.” Va. Code § 32.1-127.1:03(D)(7). As stated earlier (Section III.A.2.), in the context of a mental health commitment, where an individual may pose a danger to himself or others or be so seriously mentally ill as to be substantially unable to care for himself, disclosure of the individual’s health records is clearly necessary in connection with the individual’s care.<sup>21</sup> Unfortunately, this exception permits disclosure under Virginia law, but does not require it. Since the disclosure is not “required by law,” there is no HIPAA exception that would authorize disclosure.

Pre-Screeners and Independent Examiners are required to examine a subject, provide opinions about dangerousness, and reach conclusions about whether a subject should be held involuntarily. It would be a tortured result to conclude that a judge or special justice had no power to question the medical bases for these opinions because a health care provider is not

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<sup>19</sup> See also, Va. Code § 16.1-342 for equivalent provisions for juvenile commitments.

<sup>20</sup> Personal appearance is not required in the following circumstances: “the judge or special justice may accept written certification of the examiner’s findings if the examination has been personally made within the preceding five days and if there is no objection sustained to the acceptance of the written certification by the person or his attorney.” Va. Code § 37.2-815.

<sup>21</sup> One Working Group member expressed concern about the breadth of this exception. This exception is more broadly worded than the HIPAA treatment exception. Because it is more broadly-worded, it could be used in many cases where a Pre-Screener or Independent Examiner feels that a person requires involuntary treatment. However, if these individuals do not feel that court-ordered treatment is warranted, they may have no treatment-based reason to provide a person’s prior health information to the court, and may actually be prohibited from doing so by professional ethics.

permitted to disclose health care information within the confines of the very commitment process within which he is operating. Nevertheless, while a fair reading of Virginia law is that it authorizes disclosure of health information to a judge or special justice, it is clear that such authorization is insufficient for HIPAA compliance. The Working Group accordingly recommends statutory changes in this area.

### **3. Conclusions and Recommendations.**

While Virginia law may authorize sharing of health information with a judge or special justice in the judicial commitment process, HIPAA currently presents a barrier. Prior to the formation of the Working Group, others in the mental health field had identified this issue and have under consideration statutory modifications to clarify the Act's authority to disclose while at the same time making the provisions consistent with HIPAA.

Attached as Attachment 2 are proposed amendments to remedy the uncertainty created by HIPAA. The Working Group unanimously recommends the amendments.

The draft amendments will resolve the issue of sharing health care information. The draft takes advantage of the following HIPAA exception:

A covered entity may use or disclose protected health information to the extent that such use or disclosure is *required by law* and the use or disclosure complies with and is limited to the relevant requirements of such law.

45 CFR § 164.512(a)(1)(emphasis added).

The proposed addition to Title 37.2 (with parallel amendments to the Act and to the juvenile and criminal procedure titles) would "require by law" the disclosure of information between and among all participants in the commitment process. As such, any appropriate use or disclosure of such information would be permitted by HIPAA.

The Working Group is aware that the draft mandates the sharing of information, a principle that the Working Group would prefer to avoid. However, just as with the amendment required to assure that disclosure to counsel was HIPAA-compliant (Section II of this Report), such a requirement is necessary to meet HIPAA's "required by law" exception for disclosures. The Working Group unanimously agreed that mandatory disclosure was the best way to comply with HIPAA.<sup>22</sup> It also has the important advantage of removing any ambiguity that may exist with respect to the authority of a provider to share health care information during the commitment process.

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<sup>22</sup> To the extent that psychotherapy notes would be of importance, a statutory mandate to disclose them would fall within HIPAA's and the Act's exception to the prohibition on disclosure of psychotherapy notes.

**C. What health care information that would otherwise be confidential is available to the public as a result of a commitment hearing? What health care information should be publicly available? Is statutory change or clarification necessary or desirable?**

Once the health information is gathered and the commitment process crosses into the courtroom, the conflict between an individual's right to the protection of his health information and the public's expectation of openness of the proceedings is squarely pitched. This conflict between privacy and public access plays out in two distinct areas – the hearing itself, and access to records after the hearing.

**1. The Court should have statutory authority to close the commitment hearing.**

With respect to the hearing, the presumption is that it will be open to the public.<sup>23</sup> There are sound policy and practical reasons for the hearing being open, including the public's right to know of a potentially dangerous individual, and the ability to ensure that courts fairly uphold the rights of the subject of the hearing. There are just as sound countervailing policy and practical reasons for the hearing being closed, including the spectacle of the public airing of the subject's most private and confidential records, and the danger of stigma and embarrassment to the subject. Currently, there is little consistency in balancing the conflicting considerations. For example, Va. Code § 37.2-818(B) requires the court to keep its copies of medical records confidential (if requested by the subject), but the hearing that produced those same sensitive records was already open to the public, which was free to hear the testimony about the contents of the records.

Health information must be protected from public disclosure. To better balance the conflicting interests, the Working Group recommends that the presumption should remain that hearings be open to the public, but the judge or special justice should have the statutory authority (if not the statutory mandate upon motion of the subject of the hearing, *see below*) to close hearings in the interest of privacy when discussing medical records and information. Subject to the discussion below, the decision to close the hearing may be on a motion from any party or on the judge's or special justice's own motion. The subject should have the option of having any person present.

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<sup>23</sup> “The [commitment] hearing [for involuntary admission] provided for pursuant to §§ 37.2-814 through 37.2-819 may be conducted by the district court judge or a special justice at the convenient facility or other place open to the public provided for in § 37.2-809, . . .” Va. Code § 37.2-820.

The presumption of open hearings applies to adult commitment proceedings only. The presumption for juvenile commitment proceedings is that the hearings are closed – “The hearing shall be closed to the public unless the minor and petitioner request that it be open.” Va. Code § 16.1-344. Different public policy concerns apply to minors, and the Working Group's discussion and recommendations as to the openness of hearings do not address the juvenile commitment process.

While the Working Group is unanimous that, at a minimum, the judge or special justice should have the statutory authority to close hearings, it could not reach consensus on the appropriate standard to be used if closure is requested by the subject of the hearing. Some members argued passionately that the subject, whose mental health status and most personal and confidential records are at issue, should have the absolute right to close the hearing, with or without cause. Other members argued just as passionately that closed hearings are inconsistent with the presumption of the public's right to access judicial proceedings, and inconsistent with the concept that openness exposes deficiencies and permits improvements in the process and, therefore, closure should be within the court's sound discretion after balancing the privacy and best interests of the subject of the hearing against the best interests of the public. Thus, while the Working Group unanimously recommends that the statutory authority to close hearings be codified in Va. Code § 37.2-820, since it could not reach consensus on the standard with respect to the subject's ability to close the hearing, and because this is such an important and fundamental policy issue, the Working Group poses the issue for resolution by the Commission and, ultimately, the General Assembly.<sup>24</sup> The Working Group will be drafting statutory amendments to authorize judges and special justices to close hearings upon appropriate findings, and will incorporate the Commission's guidance on the standard to be applied to a motion by the subject to close his hearing.

The Working Group examined the constitutionality of closing civil commitment hearings, and found no constitutional impediment. First, the Attorney General of Virginia, acknowledging that civil commitment hearings are generally open to the public, has opined that a judge may order a civil commitment hearing closed for good cause. 2003 OP. VA. ATT'Y GEN. 124. Secondly, civil commitment hearings that are closed by statute in all circumstances have withstood scrutiny. In North Carolina, by statute, both outpatient and inpatient civil commitment hearings are "closed to the public unless the respondent requests otherwise." N.C. Gen. Stat. §§ 122C-267(f) (outpatient) and 122C-268(h) (inpatient). The statutes have been upheld against constitutional attack.<sup>25</sup>

## **2. Records should be confidential, subject to limited public access.**

With respect to the records of the proceedings and medical records, the Working Group recommends that all such records should be presumptively confidential. That is not the case under current law. As noted above, Va. Code § 37.2-818(B) provides that the court shall keep records confidential, but only if requested by the subject or his counsel. Presumably, there are many involuntary commitment hearings in which the subject did not specifically request that his medical records be kept confidential, and those highly sensitive records are open to public view. The Working Group recommends that the presumption of Va. Code § 37.2-818(B) be reversed and that the records of the proceedings and the medical records be confidential. Notwithstanding

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<sup>24</sup> With respect to closure on a motion from anyone other than the subject, the Working Group agreed that the decision should be in the court's sound discretion based on the balancing test articulated.

<sup>25</sup> *In re Belk*, 107 N.C. App. 448, 420 S.E.2d 682 (1992). See also, *People v. Dixon*, 148 Cal. App. 4th 414; 56 Cal. Rptr. 3d 33 (2007).



the presumption of confidentiality, the proceeding is about the subject and he should have the unfettered right to access the records of his own involuntary commitment proceeding.

The Working Group is cognizant of the fact that there are those who have a legitimate interest in knowing the outcome of the proceedings (*e.g.*, family; concerned individuals; educational institutions). Public access to the records of the proceedings (which include the subject's medical records) should be limited to the dispositional order. Other than providers who will be treating the subject, the Working Group cannot conceive of a legitimate reason for anyone else to have access to the sensitive medical records of an individual. Hence, the Working Group recommends that access should be to the order only, and only upon an appropriate showing, and that this limitation should be codified. Attachment 3 is a draft of the suggested amendments to Va. Code § 37.2-818 to accomplish the above recommendations.<sup>26</sup>

The existing form used for involuntary commitments contains everything from the initial Petition, with clinical information and allegations of mental illness, to the dispositional order. The Working Group recommends that the order be separated from all other parts of the existing form so that, if an appropriate showing is made, only the separate order is disclosed.

Access to the order for those who can make an appropriate showing should not be unduly delayed. Thus, the Working Group recommends that a form motion to request access be developed, and that the form be reviewed on an *ex parte* expedited basis. Training should be developed to provide uniformity among the courts in dealing with motions for access to the dispositional order.

Consistent with the above, care should be taken when the order is prepared. The order should incorporate the treatment plan by reference, but should not reiterate it.

All of the above assumes that involuntary commitment has been ordered. In those cases in which a Petition is dismissed, a majority of the Working Group recommends that all records and documents related to the hearing, including the order, be confidential. There is a minority position on this issue. Some members felt that a person could be in distress and in serious need of medical assistance, even though the person may not have met the standards of involuntary commitment. Consequently, the minority position is that access to records of a dismissed Petition should be through the same process as access to records (the dispositional order) in cases that were not dismissed.

There is an additional minority position with respect to access when involuntary commitment has been ordered. The minority position is that the order should be a public document. The same policy reasons supporting the current public access to the hearing apply equally to public access to the order. Further, as a public document, parents, concerned family

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<sup>26</sup> Notwithstanding the confidentiality imposed by the amendments, the amendments include the authority of the Virginia Supreme Court to access the records without limitation. Based on the Working Group's deliberations, it is clear that the commitment process would be well served by greater consistency among the many jurisdictions. A centralized database that included the important commitment records – emergency custody orders, commitment petitions, temporary detention orders, commitment hearing records and commitment orders – would allow appropriate oversight and quality control, and the Supreme Court is well-positioned to provide that role.

and educational institutions will have ready access. Moreover, allowing public access supports public safety by making known those who have been determined to be a danger to themselves or others.<sup>27</sup>

Finally, there is also a minority position that no dispositional order should be a public document, regardless of whether the petition for involuntary commitment has been dismissed or has been granted. This minority position holds the order should remain confidential in all circumstances.

#### **IV. CONCLUSION**

In summary, the Working Group found that Virginia law permits a health care provider to disclose confidential health information along the continuum of the treatment evaluation and judicial decision-making processes. But, Virginia law is subject to the HIPAA overlay and, without amendments to Virginia law, HIPAA prohibits disclosures that Virginia otherwise allows.

HIPAA provides a treatment exception to its prohibition against disclosure without an individual's authorization. To restate that exception, HIPAA allows disclosure by a healthcare provider to a third party for purposes of treatment for which the provider is responsible; HIPAA's treatment exception also allows disclosure by a provider to facilitate treatment by another health care provider. Disclosures to a Pre-Screener or an Independent Examiner, who perform assessments for treatment purposes by virtue of their training and statutory responsibilities, clearly fall within the latter prong of the treatment exception. But the Working Group could not comfortably fit disclosure to the special justice or district court judge within the treatment exception. Instead the Working Group found that it is necessary to create a mandatory disclosure under state law so that HIPAA's "required by law" exception to an unauthorized disclosure would apply to disclosures to the judicial decision-maker.

In light of privacy concerns and the mandatory flow of information recommended to facilitate the judicial process, the Working Group recommends tighter controls over public and third party access to the health information and decisions produced within the process. The extent of those controls was the subject of differing positions that are set out in this Report.

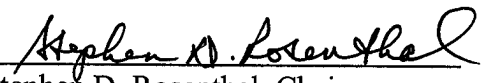
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<sup>27</sup> While there is some merit to the minority position, it is instructive that § 37.2-819 mandates the Central Criminal Records Exchange to keep confidential an order of involuntary commitment:

§ 37.2-819. Order of involuntary admission forwarded to CCRE; firearm background check. The clerk shall certify and forward forthwith to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any order for involuntary admission to a facility. The copy of the form and the order shall be kept confidential in a separate file and used only to determine a person's eligibility to possess, purchase, or transfer a firearm.

Respectfully submitted,

Working Group on Health Privacy and the  
Civil Commitment Process

By:   
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Commission on Mental Health Law Reform  
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1. **Add a new section § 37.2-804.2:**

§ 37.2-804.2. Disclosure of records.

Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a person who is the subject of proceedings under this chapter shall disclose to a magistrate, the court, the person's attorney, the examiner required under § 37.2-815, the community services board or behavioral health authority or the designee of the board or authority performing evaluation, preadmission screening, or monitoring duties under this chapter, or a law enforcement officer any and all information as requested or as may be necessary and appropriate to enable each of them to perform their duties under this chapter. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment.

2. **In § 32.1-127.1:03.D., add a new subsection 13 after subsection 12.**

§ 32.1-127.1:03. Health records privacy

\* \* \* \* \*

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

13. To a magistrate, the court, the examiner required under § 37.2-815, a community services board or behavioral health authority or a designee of a board or authority, and law enforcement officers participating in any involuntary admission proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, § 19.2-176 or § 19.2-177.1, or Chapter 8 of Title 37.2 regarding the subject of the proceeding and to any health care provider evaluating or providing services to the subject of the proceeding or monitoring the subject's adherence to a treatment plan ordered under those provisions.

3. **Add a new subsection B. to § 16.1-337 as follows [provides consistency with new § 37.2-804.2. Sections 16.1-342 and 16.1-343 already require access to records for the evaluator, CSB, and minor's attorney]:**

§ 16.1-337. Inpatient treatment of minors; general applicability.

- A. A minor may be admitted to a mental health facility for inpatient treatment only pursuant to §§ 16.1-338, 16.1-339, or § 16.1-340 or in accordance with an order of involuntary commitment entered pursuant to §§ 16.1-341 through 16.1-345. The provisions of Article 12 (§ 16.1-299 et seq.) of Chapter 11 of this title relating to the confidentiality of files, papers, and records shall apply to proceedings under §§ 16.1-339 through 16.1-345.

B. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a minor who is the subject of proceedings under this article shall disclose to a magistrate, the juvenile intake officer, the court, the minor's attorney as required in § 16.1-343, the evaluator as required under § 16.1-342, the community services board or behavioral health authority performing evaluation, preadmission screening, or monitoring duties under this article, or a law enforcement officer any and all information as requested or as may be necessary and appropriate to enable each of them to perform their duties under this article. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment.

4. **Add a new subsection D. to § 19.2-169.6 as follows [provides consistency with new § 37.2-804.2.]**

§ 19.2-169.6. Emergency treatment prior to trial.

\* \* \* \* \*

D. Any health care provider, as defined in § 32.1-127.1:03, or other provider rendering services to a defendant who is the subject of a proceeding under this section, § 19.2-176, or § 19.2-177.1 shall disclose to a magistrate, the court, the defendant's attorney, the qualified mental health professional, the community services board or behavioral health authority performing evaluation, preadmission screening, or monitoring duties under these sections, or the sheriff or administrator of the jail any and all information as requested or as may be necessary and appropriate to enable each of them to perform their duties under these sections. These health care providers and other service providers shall disclose to one another health records and information where necessary to provide care and treatment to the person and to monitor that care and treatment.

**Section 37.2-818 should be amended to provide that recordings and records of the commitment hearing shall be kept confidential, with access provided to the dispositional order only upon court order as follows:**

§ 37.2-818. Commitment hearing for involuntary admission; recordings and records.

A. The district court judge or special justice shall make or cause to be made a tape or other audio recording of ~~the commitment hearing~~ any hearings held under this chapter and shall submit the recording to the ~~appropriate district court clerk~~ of the general district court in which the hearing is held to be retained in a confidential file. The person who was the subject of the hearing shall be entitled, upon request, to obtain a copy of the tape or other audio recording of his hearing. ~~Recordings shall be used only to document and to answer questions concerning the judge's or special justice's conduct of the hearing.~~ These recordings shall be retained for at least three years from the date of the commitment hearing.

B. Except as provided in this section and § 37.2-819, the court shall keep its copies of the recordings referenced above, relevant medical records, reports, and court documents pertaining to the ~~hearing~~ hearings provided for in this section chapter confidential if so requested by the person who was the subject of the hearing or his counsel with, The person who was the subject of the hearing, or that person's legally authorized representative, may, in writing, waive the confidentiality provided herein. Otherwise, access to the dispositional order only may be provided upon court order. for good cause shown. Any person seeking the dispositional order may file a written motion setting forth why the dispositional order is needed. The court may issue an order to disclose the dispositional order if the court finds that it is in the best interest of the person who was the subject of the order or that a strong public interest in disclosure of the order overrides the privacy interest of the person who was the subject of the order. The Executive Secretary's Office of the Virginia Supreme Court and anyone acting on its behalf shall be provided access to the court's records upon request. Such recordings, records, reports, and documents shall not be subject to the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

C. After entering an order for involuntary commitment or outpatient treatment, Tthe judge or special justice shall order that copies of the relevant medical records of the person be released to: the facility in which he is placed; ~~upon the request of the treating physician or director of the facility~~ the community services board or behavioral health authority of the jurisdiction where the person resides or which is ordered to monitor any mandatory outpatient treatment order; any treatment providers identified in any treatment plan incorporated into any mandatory outpatient treatment order; and any other treatment providers or entities.