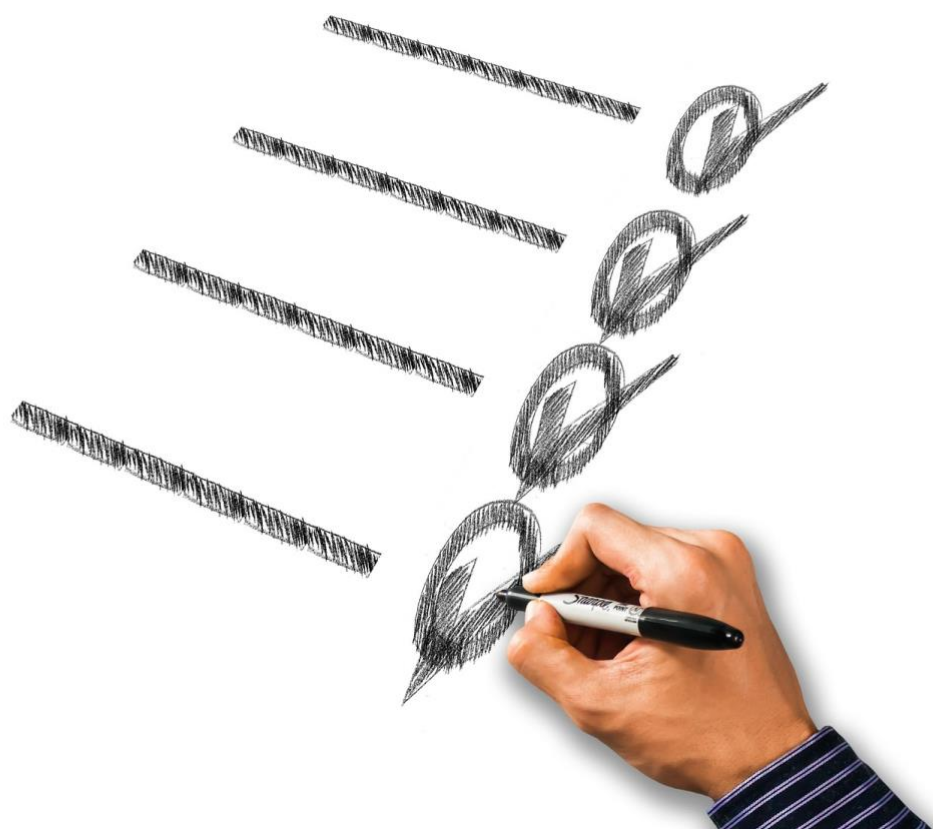




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# Ethical Concerns When Working with Children and Adolescents: Confidentiality and Consent



## Children and Adolescents: Confidentiality and Consent AND ASSENT?

In August 2015, an online exchange among members of the American Psychological Association focused in on the matter of child and adolescent assent after parents or legal guardians have given informed consent. Here is one psychologist's take on the matter of "assent." \*

"I know very few psychologists who have tried to formalize their assent procedures, with the presumed thinking being that if 'consent' is obtained from parents or legal guardians, then assent is nice but not necessary (just icing on the cake). However, this is not my take of what the APA Ethical Principles has to say about assent (see below), and as such I have tried to formalize the assent procedures we use in our practice. What I have found is that the real trick is making assent procedures developmentally appropriate for the target audience. We have developed both child and adolescent versions of assent documents ..., and will use these whenever it is developmentally/cognitively appropriate to do so. However, when not developmentally appropriate we will still cover the assent information as best we can in verbal form and then document in the progress note that assent procedures were reviewed with the client. We also let parents take a look at these assent docs to see how we are explaining things to their kids. I am not holding up our assent practices as any sort of gold standard, but here they are in case others would like to borrow from them. I would also love to see what others are doing about assent in their practices and clinics."

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From APA Ethical Principles:

### 3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

## I. The Basics

### A. Overview: What is it all about and why is it important?

#### ***Understanding Confidentiality & Minor Consent\****

Excerpts from: Taylor, L. & Adelman, H.

Reframing the confidentiality dilemma to work in children's best interests.

*Professional Psychology: Research & Practice*, 20, 79-83.

[http://www.researchgate.net/publication/232516457\\_Reframing\\_the\\_confidentiality\\_dilemma\\_to\\_work\\_in\\_children's\\_best\\_interests](http://www.researchgate.net/publication/232516457_Reframing_the_confidentiality_dilemma_to_work_in_children's_best_interests)

Confidentiality is an ethical concern. The fundamental intent is to protect a client's right to privacy by ensuring that matters disclosed to a professional not be relayed to others without the informed consent of the client. In discussing confidentiality, therapists also hope to encourage communication.

Neither privacy nor confidentiality, however, are absolute rights, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities.

Privileged communication is a legal concept. It addresses legal rights protecting clients from having their disclosures to certain professionals revealed during legal proceedings without their informed consent. Legal determinations regarding who is the client (e.g., whether minors or their parents hold the "privilege") and limitations on clients' rights to privileged communication are the bases for legal exceptions to maintaining confidentiality.

There are times when professionals would prefer to maintain confidences but cannot do so legally or ethically. Examples include instances when clients indicate an intention to harm themselves or someone else and when they have been abused. As a result of legislation, litigation, and ethical deliberations, professional guidelines call on interveners to breach the confidence and tell appropriate public authorities when there is a "clear danger to the person or to others" (American Psychological Association). In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority" (American Association for Counseling and Development). However, it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting.

In order to adequately inform minors of exceptions to the promise of privacy, therapists must add a statement about exceptions, such as this:

*Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the police about it. If you tell me you have made plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people?*

Because youngsters may feel a bit overwhelmed about the exceptions to privacy and the serious problems described, they may simply nod their acquiescence or indicate that they are unsure about how to respond. To soften the impact, therapists may add statements, such as this:

*Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you.*

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity. As far as professional psychology is concerned, however, the bottom line is that there is a gradual, continuous weakening in the confidentiality privilege.

Undoubtedly, breaking confidentiality in any case can interfere with the trust between client and professional and make it difficult to help the client. Prevailing standards, however, stress that this concern is outweighed by the responsibility of the intervener to prevent various threats. In particular, matters such as suicide and assault on others (including physical and sexual abuse), which initially were defined as legal exceptions to privileged communications, have become established limits on confidentiality. As a result, the ethical task of informing prospective clients about all the exceptions and limits related to confidentiality has made the processes of ensuring privacy and building trust almost paradoxical.

Existing limits on confidentiality clearly reflect circumstances in which the society sees its interests as paramount and requires counselors to disclose what they learn even though the interveners believe it may hinder their efforts to help the client. The issues related to such limits are complex, controversial, and beyond the scope of this article. For our purposes, we can simply acknowledge that society always is likely to impose some limitations on privileged communication and that counselors always will find such limits troublesome.

### ***Confidentiality as a Limitation on Helping***

Concerns about protecting a client's right to privacy and exceptions to this right have been discussed thoroughly in the literature. Less attention has been paid to the fact that there are times when keeping information confidential can seriously hamper an intervener's efforts to help a client. The complexity of the ethical issues need not concern us here. We can simply take it as axiomatic that there will be times when interveners find it in the best interest of a minor client for others to know something that he or she has disclosed.

In its ethical guidelines on confidentiality, the American Psychological Association recognizes that there are instances when information obtained in clinical or counseling relationships should be shared with others. In doing so, the guidelines stress that such sharing should occur "only with persons clearly concerned with the case" (APA). Given that teachers and parents are clearly connected and see themselves as also working in a minor's best interests, some interveners feel it appropriate-even essential-to discuss information with them. In other words, there are times when an intervener sees keeping a specific confidence shared by a minor client as working against the youngster's best interests and will evaluate the costs of not communicating the information to others as outweighing the potential benefits of maintaining the minor's privacy.

### **Informed Consent**

There was a time not so long ago when assigning students to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

Parent and student involvement have become prominent considerations in designing screening, diagnosis, and placement practices in the schools. Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. With respect to special education, this fact is reflected in the "procedural safeguards" associated with the passage of Public Law 94-142. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. The special education procedural safeguards are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent.

Some of the safeguards spelled out in law are the following:

1. Parents must be notified whenever the school plans to conduct a special evaluation of their child.
2. Parents have the right to refuse consent for such an evaluation. (However, the school district has the right to a legal hearing to prove it is needed. Should parents want a special evaluation and the school refuses to provide it, parents can seek a legal hearing.)
3. Parents have the right to:
  - review the procedures and instruments to be used in any evaluation
  - be informed of the results and review all records
  - obtain an independent educational evaluation to be considered in any decisions
4. Parents must be notified whenever the school wants to change their child's educational placement, and they have the right to refuse consent for such a change. (Again, the school district can ask for a legal hearing to overrule the parents' decision; and parents who are unable to convince the school to provide the special placement they want can also seek such a hearing.)

All notifications and explanations are to be given in the parents' primary language or other primary mode of communication.

Levine has enumerated the basic information that should be communicated and understood. These items include clarifying the purpose of the procedures (why the person is there; what the person will be doing), describing risks and benefits, spelling out alternatives, assuring the individual that participation is not required, and eliciting and answering all questions.

To make sure it is understood, such information may need to be presented in a variety of ways. Repeated verbal or written communications, translations, media presentations, question-and-answer follow-ups to evaluate whether information was understood, feedback from other consumers—all may be relevant at various times.

The emphasis on information, and the very term *informed consent*, may sometimes lead to greater emphasis on giving information than on ensuring true consent. As Biklen noted:

*It suggests that the key element of consent is the provision of information to people who are giving consent. Consent is a legal concept that has been referred to and implicitly defined in court cases and in legislation. It has three major aspects: capacity, information, and voluntariness. All three elements are equally relevant to any consent procedure or decision. Simply stated, one must have the ability to give consent in order to do so; one must have adequate information to do so in a knowledgeable way; and one must be free from coercion or any other threat to one's voluntariness.*



## ***Children's Assent***

Young people's involvement in decision making is only beginning to be discussed seriously. For example, there is increasing discussion of the need to obtain the minors' assent in addition to parental consent.

Interest in civil rights in the late 1960s, and related advocacy of minors' rights in education and mental health, has led to greater consideration of the rights of children and adolescents to be involved in making decisions that affect them. Concomitantly, long-standing controversies have reemerged about the risks and benefits of young people's involvement in decision making and their competence to make appropriate decisions.

## ***Consent***

In a society that values fairness and personal liberty, consent is a very important concept. Such a society has a strong commitment to ensuring personal autonomy for everyone. Children and individuals with problems often are treated in ways that diminish their autonomy. This occurs because of assumptions about their relative lack of competence and wisdom. Even when they are treated autonomously, their decisions may not be respected.

The idea that autonomy should be respected has made consent not only a legal but also a major moral concern. The legal and moral mechanism for maintaining autonomy usually is designated *informed consent*. Six major functions served by the consent mechanism are the promotion of individual autonomy, the protection of clients or subjects, the avoidance of fraud and duress, the promotion of rational decisions, the encouragement of self scrutiny by professionals, and the involvement of the public in promoting autonomy as a general social value and in controlling professional practices and research.

The desirability of such outcomes seems evident. The problems and issues involved in appropriately eliciting consent have to do with such matters as: When is consent needed? When is it justified for one person to offer consent for another? Who decides when consent is needed and when one person can represent another? What information must be given in eliciting consent? How can anyone be certain that consent has been voluntarily given? Each of these questions raises significant dilemmas for professionals.

To highlight major concerns associated with the concept of consent, we focus on (1) competence and paternalism as they affect decisions about when consent must be elicited and from whom, and (2) the nature of relevant information and voluntary consent.

## ***The Question of Competence and the Problem of Paternalism***

Competence in the context of consent refers to the ability to understand (the ability to receive and process information, make decisions, and choose from among alternatives). Criteria for deciding about the adequacy of these abilities are difficult to specify. Usually very general criteria are established, such as age and mental status.

Children--and those diagnosed as mentally retarded, autistic, or psychotic--usually are seen as incompetent in a legal sense and in need of surrogates (parents, guardians, and courts) to give consent. However, the basis for deciding what constitutes competence and when others should act remains controversial. The example of children's consent illustrates just how difficult the problem is. At what age should it be necessary to ask a child's consent before involving the child in a psychological or educational intervention (including testing)? With certain school assessment activity, the legal answer is that no individual consent is needed from either parents or child through the age period when attendance is compelled by the state. With regard to special psychological testing, special class placement, and therapeutic treatments, the common answer is that only the parents' consent is needed, and in some cases not even their consent is sought.

The question of competence is strongly related to the problem of paternalism. It comes as no surprise that professionals, parents, government agents, and many others in society have opinions as to what is good for children. Such opinions backed by the power to impose them may lead to excessive paternalism.

For example, the professional who tests a youngster who does not want to be tested is confronted with this problem. It is a paternalistic act whenever a child is made to undergo unwanted assessment, even though the activity is viewed as in the child's "best interests." Whether stated or not, when such actions are taken, the child's autonomy is made less important than the possible harm to the child or others if the child is not assessed or the possible benefits to be gained if the child is assessed.

### ***Relevant Information and Voluntary Consent***

Whenever consent is to be elicited, relevant information must be provided and decisions must be made voluntarily. Relevant information must be provided in an understandable manner--a requirement that is difficult to meet when complex psychoeducational practices are used. Cultural and language differences also may be barriers in making information understandable.

Providing relevant information does not guarantee that consent is given voluntarily. In many situations, consent is given because people feel they have no meaningful alternative. For example, children in special school programs and their parents may consent to additional assessment (therapy, medication, and so forth) because of fear that if they refuse they may be asked to leave the program.

When is voluntary consent needed? In addition to legal and ethical guidelines, voluntary consent is needed whenever the intent is to establish a helping relationship. Power relationships and situations in which influence is relied upon to elicit compliance do not involve the consent of participants. In contrast, helping relationships are based on voluntary consent. Thus, by definition, the obtaining of informed and voluntary consent defines whether the intent of an intervention is social control or helping.

When may consent be waived? The answer seems clearest when a problem is extremely threatening or an intervention is extremely unthreatening. For instance, persons who are seen as immediately dangerous to others or as unable to protect or care for themselves generally are accepted as likely candidates for waivers of consent.

Activities that are common to everyday living, such as much of the assessment and evaluation activity that permeates all our lives, provide another example. But they usually are not understood in terms of waived consent. They are, however, instances of de facto waived consent.

Although ethical concerns about waived consent are most likely to be raised in cases of extreme problems and dramatic interventions, consent that is waived in a de facto manner perhaps ought to be of equal concern. Many commonplace activities, such as routine achievement, intelligence, and interest testing in schools, can have life-shaping impact and are likely to have an effect on a large segment of the population. In instances in which consent is ignored, coercion is involved and needs to be justified.

\*See article online for cited references.

## I. The Basics (cont.)

B. What is special about confidentiality when you work with children and adolescents?

### 1. Reasons for Protecting the Privacy of Children and Families

Excerpted from the North Central Regional Educational Laboratory

<http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs3lk2.htm>

When determining eligibility for certain services and providing needed and appropriate resources, human service agencies and education institutions often require that children and families share very private information about themselves. Laws and statutes are in place to protect the privacy of these individuals and to ensure that this information is released only when necessary. Soler and Peters outline several reasons for protecting the privacy of children and families:

- "Confidentiality restrictions *protect embarrassing personal information from disclosure*. This information may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.
- Confidentiality provisions also *prevent the improper dissemination of information about children and families that might increase the likelihood of discrimination against them*. Such information--about HIV status, mental health history, use of illegal drugs, or charges of child abuse--can be harmful if released. Harm can occur even if records show that the information is unproven or inaccurate.
- Protecting confidential information can be necessary to *protect personal security*. For example, in a domestic violence situation, an abused woman who leaves home may be in great danger if law enforcement personnel disclose her new location.
- Confidentiality provisions also *protect family security*. Many immigrant families, for example, shy away from using public health clinics or other social services for fear that the Immigration and Naturalization Service (INS) will take action against them.
- Restricting the information that human service agencies receive may also *protect job security*. Some information--such as a history of mental health treatment--may have no connection with a person's actual job performance but could jeopardize the individual's position, likelihood of promotion, or ability to find new positions.
- Children and families also want to *avoid prejudice or differential treatment* by people such as teachers, school administrators, and service providers. Teachers may lower their expectations for the children they know are eligible for food stamps or free school lunches. This may set in motion a self-fulfilling prophecy in which lowered expectations lead to lowered performance.
- Confidentiality provisions also may be necessary to *encourage individuals to make use of services designed to help them*. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents, or peers."



## I. The Basics (cont.)

B. *What is special about confidentiality when you work with children and adolescents?* (cont.)

### 2. Involving Parents in Counseling

<http://smhp.psych.ucla.edu/pdfdocs/practicenotes/involvingparents.pdf>

Those who work regularly with youngsters know the impact of a lack of parental commitment. For instance, when youngsters are referred for counseling, parent follow-through is estimated at less than 50%, and premature termination occurs in 40-60% of child cases (Kazdin, 1997). Clearly, not all parents feel that such counseling is worth pursuing. Even if they do enroll their child, dropping out in short order is likely if the family experiences the process as burdensome, unpleasant, or of little value. Conversely, children seem to do better when parents perceive few negatives related to the intervention and its potential outcomes (Kazdin & Wassell, 1999).

In addition to reducing dropouts, there are many reasons to involve parents. For example, it seems essential to do so when they are the cause of or an ongoing contributor to a youngster's problems. Moreover, in more cases than not, we want the family's cooperation in facilitating, nurturing, and supporting desired changes in the youngster. Equally important, what parents learn in the process may generalize to other venues, such as home involvement in school and parent advocacy.

All this underscores the importance of attending to motivation for involvement. A variety of psychological, socioeconomic, language, racial, and ethnic factors affect a parent's motivation to enroll and maintain a youngster and be active participants themselves. Based on theories of intrinsic motivation (e.g., see Ryan & Deci, 2000), we suggest ideas for: (1) using initial contacts to assess and address parent motivation for involvement and (2) maintaining their motivated involvement over time.

#### Accounting for and Enhancing Motivational Readiness

Think in terms of a range of motivational differences. With respect to their youngster's participation and their own role in the intervention process, parents range from those who are:

- highly involved (e.g., motivated and active participants who advocate for their children and seek out resources)
- marginally involved (e.g., minimally motivated and cooperative)
- reluctant to highly resistant (e.g., not at all motivated, uncooperative, avoidant, reactive).

Those in the last group often have been pushed to pursue assistance by the school or the justice system. Working to establish appropriate family cooperation and involvement often is a critical process objective at all points along the continuum. An intervener must, from first contact, assess parents' motivation for enrolling their youngster and for their own possible involvement. And, assessment processes must be designed to enhance the motivation of family members, or at least to minimize conditions that can reduce their motivation. As Ed Deci and his colleagues well articulate, this means using practices that can enhance (or at least reduce threats) to:

- feelings of competence
- feelings of self-determination
- feelings of relatedness to others.

As an intervener first encounters the family, multiple opportunities arise to assess their motivation and engender parent involvement. In doing so, it also is important to minimize perceptions of coercion and enhance feelings of control and competence by involving parents in decisions.

Following are four aspects of initial contact that require practices that account for motivational concerns:

1) *Using the consent process to assess and enhance motivation.* Informed consent presumes that participation is voluntary and that clients can terminate with no penalty or prejudice. By approaching consent as an intervention step, an intervener provides a natural opportunity for parents to express their questions, concerns, doubts, and fears. If they agree to proceed, the family has made an essential, formal commitment. That is, properly implemented, the process not only protects client rights, it can help reduce feelings of coercion and promote feelings of self-determination, enhance feelings of competence, and foster feelings of positive relatedness between the family and intervener.

At this stage, it is especially important to counter feelings of coercion and intimidation among mandated referrals. This requires reframing the referral as an opportunity for a family to explore all *their* options for improving the situation. A useful place to begin is by sharing available assessment information as a basis for discussing the problem and what to do and ways to work together. Suggesting a short time frame (e.g., 3 sessions) can help reduce the feeling of coercion, and so can choices about who the intervener will be (e.g., with respect to age, sex, ethnicity, language). Families not ready or willing to engage may need the option of a “cooling-off” period (e.g., so they can view the need in a less reactive manner).

In many settings, a youngster’s consent also must be elicited. Modeling for parents how to explain the nature of the intervention and elicit consent not only can help enhance the youngster’s participation, it helps parents further understand the importance of their involvement.

The above practices can help establish a perspective from which parents see the need for intervention and for their involvement. The ensuing decision to consent can enhance their feelings of self-determination, competence, and relatedness to the intervener.

2) *Contracting for involvement.* Negotiating a “contract” should include mutual expectations about involvement. At the outset, the focus with parents who are not highly motivated may just be on scheduling (e.g., regular appointments, arriving on time) and sharing relevant information. Over time, such initial agreements may be renegotiated to encompass greater degrees of family involvement.

To elicit appropriate involvement, an intervener must demonstrate respect for parent roles and efforts related to the youngster’s day to day experiences. This involves validating those aspects of what they are doing right. Then, discussion of what they might want to change can be initiated as one basis for clarifying why their inclusion in the process is necessary.

A special problem arises with youngsters whose parents are divorced and/or remarried. The dynamics of such families require clarifying the respective roles and involvements of each member, with particular reference to family communication and problem-solving abilities to serve intervention’s aims (Lew & Bettner, 1999).

3) *Handling privacy and confidentiality.* Concerns about privacy and confidentiality influence the nature and scope of involvement. Families vary in how much info they want interveners to share with others. One parent may want discussions kept confidential from the youngster, the other parent, and other staff at a school. Some parents are uncomfortable with the intervener holding conversations which are not shared with them.

For many, assurances of privacy and confidentiality are sufficient to enlist cooperation and participation. For others, discussion of these matters must go further (e.g., pronouncements of reporting requirements are unlikely to enhance the involvement of abusive parents). There is no easy solution to the confidentiality dilemma. One strategy that can pay dividends is to reframe the topic in ways that clarify that the intent isn’t to play a game of “keeping secrets” or to elicit info to report to authorities. To the contrary, what must be conveyed is: (a) the intent is to encourage a flow of info that is essential to solving problems and (b) when mutual sharing is necessary, the intent is to find ways to facilitate such sharing (Taylor & Adelman, 1998).

4) *Handling parent reactions to initial contacts and assessment.* Enrollment procedures may require families to complete extensive paperwork, including lengthy questionnaires asking about psychological problems. Completing such forms requires literacy and candor that may exceed a family's skills and/or motivational readiness and may reinforce negative feelings about participation. If this appears likely, an intervener must make these processes more consumer friendly by ensuring the level of discourse is a good match for the family's level of skills and motivation.

Initial assessments are a major opportunity to demonstrate and validate the importance of parent involvement. Because causal attributions for problems often play a major role in shaping behavior, data about such attributions require special attention. If parents blame themselves or each other for the child's problems, an intervener must be ready to explore these perceptions quickly and nonjudgmentally. Extra efforts may be required to convince parents that such feelings are natural and that the intervener is not assigning blame and is only seeking to correct problems.

Toward the other end of the continuum, some families are overly or inappropriately involved. This may not be evident at first. Such parents may be reluctant to allow the youngster to meet alone with the intervener; they may want more frequent appointments than is common practice or may call frequently between appointments; they may self-generate lists or logs of problem behaviors. Such behavior often calls for separate sessions with the parents to clarify their underlying motivation and elicit changes that will facilitate rather than hinder the youngster's progress.

In sum, concern about parent involvement begins at first contact. Strategies to address this concern can help move parents to perceive an intervener as a potential ally rather than an enforcer or an agent of social control.

### **Maintaining Motivation and Involvement During the Process**

Good practice calls for processes that both assess and enhance motivation not only initially, but throughout the period of intervention. Extrapolating from the literature on intrinsic motivation (e.g., Ryan & Deci, 2000), three considerations seem basic for maintaining involvement:

- ensuring parents feel a growing sense of relatedness to the intervener
- enhancing valuing by providing many desirable ways for parents to participate and, then, facilitating their decision making (including their ongoing decisions to change how they are involved)
- providing continuing support for learning, growth, and success (including feedback about the benefits of their involvement).

Such considerations play out especially in relation to intervention alliances and assignments. For example, use of "homework" provides opportunities to involve parents and develop alliances. Other occasions arise around the family's role in facilitating, supporting, and nurturing the youngster's progress.

In forming alliances with youngsters, special concerns arise. For instance, many teens are trying to develop separate identities from their families and don't want counselors having any contact with a parent. Parents, however, are likely to feel excluded and alienated from the process if the counselor avoids them. They also may feel threatened by the growing bond between their child and the intervener. Conversely, if a bond is established with one of the parents, the youngster and/or the other parent may feel threatened or jealous. Any of this may lead to abrupt and premature withdrawal of a youngster from counseling.

Counselors must (a) help all concerned parties appreciate the appropriateness and value of various alliances and (b) listen to and validate the feelings that accompany each's perceptions. The danger in not doing so is to be seen by one or more of the parties as a biased and untrustworthy person. In general, when parents understand the process and feel heard and validated, an intervener is more likely to be perceived as an ally. Such an alliance can prevent premature termination and enhance parent involvement.

There are, of course, parents who want the intervener to take over and are satisfied not to form a close alliance. The need here is to move them to middle ground as soon as feasible. This requires frequently clarifying and demonstrating that specific forms of contact are beneficial (e.g., in terms of progress and for anticipating and preventing problems).

### **Concluding Comments**

Interveners who want to enlist parent involvement must be clear about the value and forms of and barriers to such involvement. From initial contact, they must include a focus on the family's motivation and incorporate processes that avoid lowering motivational readiness and, when necessary, enhance such motivation. Clearly, this is an area where the full implications for research, theory, practice, and professional training are just beginning to be appreciated.

### **References**

- Adelman, H.S., & Taylor, L. (1994). *On understanding intervention in psychology and education*. Westport, CT: Praeger.
- Kazdin, A. E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology*, 26, 114-129.
- Kazdin, A. E. & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology*, 28, 160-172.
- Lew, A. & Bettner, B. L. (1999). Establishing a family goal. *Journal of Individual Psychology*, 55, 105-108.
- Ryan, R. M. & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55, 68-78.
- Taylor, L. & Adelman, H. S. (1998). Confidentiality: competing principles, inevitable dilemmas. *Journal of Educational and Psychological Consultation*, 9, 267-275.

## I. The Basics (cont.)

### C. Dilemmas in confidentiality in working with children and adolescents

#### 1. Limits

##### 1A. FACT SHEET

#### ***Limits of Confidentiality***

##### ***Duty to Warn***

Court cases have held that when an individual indicates the intention of doing something harmful, dangerous, or criminal to self or others, it is the professional's duty to warn appropriate parties. This includes:

- \_\_\_ The family of an individual who intends to harm her- or himself
- \_\_\_ Others the individual actions may harm
- \_\_\_ Appropriate authorities and emergency responders

##### ***Duty to Report Child Abuse and Dependent Adult/Elderly Abuse***

Many states mandate reports to appropriate agencies and authorities whenever there is actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

Many states also require reporting whenever there is actual or suspected abuse to dependent adults and the elderly.

## **I. The Basics (cont.)**

### **C. Dilemmas in confidentiality in working with children and adolescents**

#### **1. Limits (cont.)**

#### **1b. Limits to Confidentiality for Teachers and Students.**

Excerpted from: *Guidelines: The Dilemma of Confidentiality*, by Rachael Kessler,  
The PassageWays Institute

<http://www.passageways.org/confident.html>

### **LIMITS TO CONFIDENTIALITY FOR THE TEACHER**

As teachers, we have always communicated the limits to our own confidentiality.

- Suicide threats or ideation
- child abuse
- drug/alcohol use on campus

They all require immediate reporting of situation to an administrator followed by an appropriate referral. These are mandated by state law or school policy. In addition, we tell them that if we feel concerned for their health or well-being, we may feel compelled by our own personal caring to share our concerns with a dean. In both cases, we assure students that if at all possible, we would speak to them first and include them in the process of choosing the appropriate administrator and include them in the visit. However, if we cannot reach the student and there is immediate cause for concern, we must break confidentiality and make our report.

The procedure and policies regarding limits to teacher confidentiality have not changed. But what has changed over the years of experience is our approach to student confidentiality.

### **LIMITS TO CONFIDENTIALITY FOR THE STUDENT**

We realized that for adolescents it is not always appropriate to expect. It is often difficult at this age to contain emotionally loaded information. I begin the process with my students by asking them why they think people tell other people's private thoughts and feelings. We then engage in a dialogue, which helps them become conscious, and therefore less likely to indulge in some of the negative reasons for violating confidentiality. We also explore the legitimate reasons why people feel compelled to tell another's story.

One of the first things students mention is gossip. I ask them why they think people gossip. They acknowledge the power and popularity it can bring. I suggest that we could agree here not to use other people's stories in this way and they nod their heads. What else? They talk about thoughtlessly blurting out something private because it is interesting or exciting to them. This too, an impulsive and unconscious violation of the privacy of others, we agree is something we will do our best to control.

Then we move into some of the more legitimate concerns that can lead any of us to tell the story of another. We may break confidentiality out of a genuine need to take care of ourselves -- someone else's private disclosure may stir a deep emotional response or concern in the listener which cannot and should not be kept to oneself. At such times, there is a conflict between the need to take care of the other (maintain confidentiality to protect their privacy) the need to take care of oneself (to share and get support or clarification for feelings that arise in response to another's sharing). This is an important part of being human and searching for integrity. We need to explain this to our students and brainstorm ways to resolve this conflict in ways that minimize hurt to both sides.



**For the speaker:**

Since confidentiality can't be guaranteed, take care of yourself and only share what you are comfortable sharing. Once you put it out, you can't predict what will happen to it. So be conscious of that when you speak; be discriminating about what you share and when, knowing that it may get out beyond the group.

**For the listener:**

If you feel the need to share something that was spoken by someone in class, ask yourself why you are doing so and how you can do it in a way that takes care of your need while not hurting your classmate. Be sure you don't just blurt it out without thinking or because it seems thrilling to you. If, on the other hand, it is really upsetting to you and you need to talk to someone about it, whom can you talk to?

We brainstorm together on this dilemma. Students suggest people they could talk to who would be least likely to violate the privacy of their classmate. Suggestions include: talk to the person who actually spoke about it, talk to your teacher, bring it up in the next class if you can wait a week, talk to your parents, talk to a friend or relative who lives outside this community. As suggestions are made, we often ask students how they would feel about something they said being repeated to a person in the category suggested. I find that students continue to insist that they can be absolutely confidential and that they want others to "swear to secrecy," but this discussion helps them to appreciate in a realistic and compassionate way that someone may need to break confidentiality. It helps them be more aware about what they share and hopefully, to be better able to forgive if there is a breach of confidentiality.

Parents' concerns about confidentiality. Some individual parents, as well as organized parent groups today, are deeply suspicious of programs that encourage students to tell personal stories or share feelings. One such program was attacked precisely because confidentiality was encouraged. As teachers and trainers, we must be sensitive to, and accountable to parents' needs and beliefs in this arena. It is always important to dialogue early with parents when programs that deal with emotions are initiated. We can convey that we are not encouraging their children to tell their own or family secrets or probe into private matters. When we encourage students to honor the privacy of others, we are teaching children to respect boundaries -- their own and those of others. Boundaries are weak and unclear for many adolescents, especially during the middle school years, and strengthening boundaries is an essential part of developing a healthy identity. Giving parents a chance to express their concerns, questions and suggestions about the content and strategies of our work is an important part of the collaborative process of designing a social and emotional learning program that has integrity and consistency throughout the lives of the students who receive it.

## I. The Basics (cont.)

### C. Dilemmas in confidentiality in working with children and adolescents (cont.)

#### 2. How to address confidentiality dilemmas and share information appropriately

##### **2a. A Brief Discussion of the Confidentiality Dilemma**

(For a more extensive discussion of this topic, see L. Taylor & H. Adelman (1989). Reframing the confidentiality dilemma to work in children's best interests, *Professional Psychology: Research and Practice*, 20, 79-83.)

**W**e all value client confidentiality. At the same time, we are aware of the legal responsibility to report endangering and illegal acts. Such reporting requirements naturally raise concerns about the negative impact on the counseling relationship.

In reaction to what they see as an erosion of confidentiality, some interveners communicate only what the law compels. Others are so overwhelmed by reporting requirements that they turn the concept of confidentiality inside out. For example, a drug counselor recently stated:

*“I explained confidentiality: that if he told me anything about the possibility of hurting himself or anyone else or about taking an illegal substance I would have to tell others, including his parents and the authorities”.*

Concern for reporting so dominated him that concerns about protecting privacy and establishing trust were not addressed.

Clearly, there is a dilemma. On the one hand, an intervener must avoid undermining confidentiality and privileged communication; on the other hand, s/he must give appropriate information to others who share concern and responsibility for a minor's welfare. It is tempting to resolve the dilemma by reasserting that all counseling information should be confidential and privileged. Such a position, however, ignores the fact that failure to share germane information can seriously hamper efforts to help the client.

In working with minors, concerns about the limits on confidentiality may be best approached by reframing the problem and focusing on how to facilitate *appropriate* sharing of information. From this perspective, we have come to focus less on how to avoid breaching confidences and more on how to establish the type of working relationship where young clients take the lead in sharing information when appropriate. To these ends, we stress processes to enhance client motivation and empower them to share information when it can help solve their problems. In addition, steps are taken to minimize the negative consequences of divulging confidences.

#### **Enhancing Motivation for Sharing**

Informing clients about reporting requirements can compound negative attitudes toward intervention. Thus, there may be a need for systematic efforts to enhance motivation to participate. The problem, of course, is a bit paradoxical: that is, how to elicit sufficient participation to allow the counselor to demonstrate that participation is worthwhile.

One strategy involves demonstrating to the client intrinsic payoffs for taking the risk of disclosing personal thoughts and feelings. We start with the assumption, born of experience, that first contacts

allow sufficient access to encourage attendance for a couple of sessions. That is, we know that skilled therapists use a range of nonthreatening activities to help establish enough rapport that most youngsters are willing to return at least for a second session. The following ideas for enhancing motivational readiness build on this initial rapport.

Available theory and research suggest the place to begin enhancing motivational readiness to disclose is to find any area in which the client expresses a personal interest. These include areas of strength, success, or problems, reactions to being referred, and so forth. Sometimes the area is clear. For instance, some young clients, perhaps in an effort to feel more in control of the situation, lead the intervener away from the referral problem to talk about some other matter. In such cases, initially we follow their lead. Almost inevitably, once they start talking about their lives, they share some complaint or problem. Some act surprised about being referred. In these cases, we begin by sharing in a nonjudgmental way the concerns expressed by parents or teachers and then try to mobilize clients to share their perspectives (often they are very motivated to rebut what others have said). We find many who respond best initially to the structure of a question and answer format that explores areas of personal concern (e.g., instruments such as the Children's Depression Inventory). Structured interviews provide a useful framework to identify openly an area of concern that can be discussed to some extent.

By identifying a problem the client expresses a personal desire to resolve and probably can resolve with some help, the intervener then is in a position to validate feelings and encourage exploration of cause and correction.

For example,

*"You feel like your teacher doesn't listen and treats you unfairly. I'll bet if we thought a bit about it, we could come up with some ways to make things better for you. Tell me what you've tried or would like to try, and then we'll figure out what to do."*

Once a mutual objective is established, the focus shifts to strategies for maintaining client motivation in working toward a solution. This, of course, involves ensuring that the client experiences a sense of satisfaction in working with the therapist. From a motivational perspective, such satisfaction results from the type of (a) options and choices that enhance feelings of self-determination (e.g., perceived control) and (b) support, guidance, skill development, and feedback that enhance feelings of competence (e.g., self-efficacy).

Several problems may have to be worked through before a young client will disclose something perceived as risky. Hopefully, when the risk is taken, the matter is one that can be kept private. Whenever a matter is raised that must be shared, we suggest use of strategies that empower clients to take the lead in sharing the information with others.

### ***Empowering Clients to Share Information***

Empowerment of clients can be viewed as a defining characteristic and a primary aim of a helping relationship. That is, a fundamental concern of an intervener in offering a helping relationship is to act in the *best interests of the client, as defined by the client*, through an informed agreement about ongoing client participation in decision making about means and ends. The ultimate intent is to empower clients so they can independently pursue their best interests. To accomplish this, intervention focuses on enhancing a client's motivation and skills for autonomous functioning.

In contrast, socialization interventions give primary consideration to the *society's best interests*. Individual consent and decision making are not necessarily sought, and empowerment of the individual is pursued only if it is consonant with the socialization agenda. Fortunately, individual and societal interests often are in harmony. However, instances where confidentiality is limited by

law are indicative of circumstances where individual and societal interests conflict and where society's interests predominate.

All of this has direct implications for divulging information when the intervener views this as in the client's best interests. In a helping process, the first responsibility of the intervener is to determine whether the client agrees that information should be shared. If the client doesn't agree, the intervener must be prepared to help the client explore (in a developmentally appropriate way) the costs and benefits involved. This may take some time, especially since the point is not to convince or seduce but to facilitate comprehension (e.g., understanding of the positive impact sharing can have on relations with significant others). In the end, the individual still may not agree, and the ethics of the situation may dictate that the intervener break confidentiality without consent.

If the client sees it in his or her interest to have others informed of certain matters, then discussion shifts to how this will be accomplished. Again, in keeping with a commitment to empowering the client, the client should be in control of what information is shared, and, if feasible, should be the one who does the sharing.

Ideally, helping and socialization come together as the counselor helps a client understand the value of relating positively to significant others (e.g., parents, teachers) with respect to sharing feelings, expressing needs, and working toward agreements.

### **Minimizing Negative Consequences of Disclosure**

Whatever the benefits, divulging confidences can have costs (e.g., for the client and for others). Ethically and practically, the intervener must take steps to minimize these costs. For example, part of the problem may be reduced if, in explaining to the client the need for relating what has been learned, the client agrees that the case falls within the previously discussed limits on confidentiality, such as harm to self or others. The costs to the individual also may be reduced significantly in instances where it is feasible to share information without revealing the source's identity.

In general, when legal or ethical considerations compel an intervener to divulge confidences, three steps must be taken to minimize repercussions. Essentially, the steps involve (a) an explanation to the client of the reason for disclosure, (b) an exploration of the likely repercussions in and outside of the counseling situation, and (c) a discussion of how to proceed so that negative consequences are minimized and potential benefits maximized.

For example, in explaining reasons, one might begin with

*"What you have shared today is very important. I know you're not ready to talk about this with your parents, but it is the kind of thing that I told you at the beginning that I am required to tell them."*

One might explore repercussions for the helping relationship by stating

*"I know that if I do so you will be upset with me and it will be hard for you to trust me anymore. I feel caught in this situation. I'd like us to be able to work something out to make this all come out as good as we can make it".*

With respect to how to proceed, often it is feasible simply to encourage the client to take actions in keeping with his/her best interests or give consent to allow the counselor to do so.

*"This may work best for you if you tell them -- rather than me. Or if you don't feel ready to handle this, we both could sit down with your parents while I tell them".*

### ***Concluding Comments***

Responsible professionals want to avoid both surrendering the confidentiality surrounding counseling relationships and overreacting to necessary limitations on confidences. In trying to combat encroachments on privileged communication, counselors recognize that the assurance of confidentiality and legal privilege are meant to protect a client's privacy and help establish an atmosphere of safety and trust. At the same time, it is important to remember that such assurances are not meant to encourage young clients to avoid sharing important information with significant others. Such sharing often is essential to the client's personal growth. Indeed, it is by learning how to communicate with others about private and personal matters that clients can increase their sense of competence, personal control, and interpersonal relatedness, as well as their motivation and ability to solve problems.



## I. The Basics (cont.)

### C. Dilemmas in confidentiality in working with children and adolescents (cont.)

#### 2. How to address confidentiality dilemmas and share information appropriately (cont.)

### 2b. A Brief Discussion of Minor Consent

The following excerpts from Abigail English's introduction to *State Minor Consent Statutes: A Summary\** provide an overview of *The Legal Framework for Minor 'Consent'*

... The issues which arise most frequently in providing health care to adolescents who are minors fall into three specific areas:

1. Consent: who is authorized to give consent and whose consent is required?
2. Confidentiality: who has the right to control the release of confidential information about the care, including medical records, and who has the right to receive such information?
3. Payment: who is financially liable for payment and is there a source of insurance coverage or public funding available that the adolescent can access?

### The Legal Framework

... delivery of adolescent health care has evolved in several significant ways. First, the courts have recognized that minors, as well as adults have constitutional rights, although there has been considerable controversy concerning the scope of those rights. Second, a growing number of states are enacting statutes to authorize minors to give their own consent for health care. Third, the financing of health care services for all age groups and income levels is undergoing major change ...

In discussing *constitutional issues*, the author states: Beginning with *In re Gault* in 1967, in which the United States Supreme Court stated that "neither the Fourteenth Amendment nor the Due Process Clause is for adults alone," the Court has held repeatedly that minors have constitutional rights. The *Gault* decision, which accorded minors certain procedural rights when they are charged by the state with juvenile delinquency offenses, was followed by others recognizing that minors also had rights of free speech under the First Amendment (*Tinker v. Des Moines Independent School District*, 1969), and that they had privacy rights as well (*Planned Parenthood of Missouri v. Danforth*, 1976, and *Carey v. Population Services International*, 1977). Although the Supreme Court subsequently rendered decisions which were more equivocal about the scope of minors' constitutional rights, the basic principles articulated in the early cases still stand.

The area of most frequent constitutional litigation--and to some degree the greatest controversy has been the rights of minors with respect to reproductive health care, particularly abortion. The *Carey* case clearly established that the right of privacy protects minors' access to contraceptives, while the history of constitutional litigation with respect to abortion has been more complex. Following the decision in *Danforth*, which held that parents do not have an arbitrary veto power with respect to the abortion decision of their minor daughters, the Supreme Court decided several additional cases--beginning with *Bellotti v. Baird* in 1979 and culminating most recently with *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992--addressing parental notification and consent issues related to abortion. The import of these cases has been that while a state may enact a mandatory parental involvement requirement for minors' abortions it must also, at minimum, establish an alternative procedure, usually known as a "judicial bypass." In the bypass proceeding a minor must be permitted, without parental involvement, to seek

a court order authorizing an abortion: if she is mature enough to give an informed consent, the court must allow her to make her own decision and, if she is not mature, the court must determine whether an abortion would be in her best interest. ...

[The author also highlights *state and federal statutes*.]



## **Consent**

The law generally requires the consent of a parent before medical care can be provided to a minor. There are, however, numerous exceptions to this requirement. In many situations someone other than a biological parent -- such as a foster parent, a juvenile court, a social worker or probation officer--may be able to give consent in the place of the parent. Moreover, in emergency situations care may be provided without prior consent in order to safeguard the life and health of the minor. Most significant for the adolescent health care practitioner, however, are the legal provisions which authorize minors themselves to give consent for their care. These provisions are typically based on either the status of the minor or the services sought.

All states have enacted one or more provisions which authorize minors to consent to certain services. These services most frequently include: pregnancy related care; abortion, diagnosis and treatment for STDs, HIV disease or AIDs, and reportable or contagious diseases; examination and treatment related to sexual assault, counseling and treatment of drug and alcohol problems; and mental health treatment, especially outpatient care. Some of these statutes contain age limits, which most frequently fall between age 12 and age 15.

Similarly, all states have enacted one or more provisions which authorize minors who have attained a specific status to give consent for their own health care. Pursuant to these provisions, the following groups of minors may be authorized to do so: emancipated minors; those who are living apart from their parents; married minors; minors who are the parents of a child; high school graduates; and minors who have attained a certain age. Moreover, in a few states explicit statutes authorize minors who are "mature minors" to consent for care.

### **The Mature Minor Doctrine and Informed Consent**

Even in the absence of a specific statute, however, "mature minors" may have the legal capacity to give consent for their own care. The mature minor doctrine emerged from court decisions, primarily state court decision, addressing the circumstances in which a physician could be held liable in damages for providing care to a minor without parental consent. Pursuant to the doctrine, there is little likelihood that a practitioner will incur liability for failure to obtain parental consent in situations in which the minor is an older adolescent (typically at least age 15) who is capable of giving an informed consent and in which the care is not high risk, is for the minor's benefit, and is within the mainstream of established medical opinion. In fact, during the past few decades diligent searches have found no reported decisions holding a physician liable in such circumstances solely on the basis of failure to obtain parental consent when non-negligent care was provided to a mature minor who had given informed consent. The basic criteria for determining whether a patient is capable of giving an informed consent are that the patient must be able to understand the risks and benefits of any proposed treatment or procedure and its alternatives and must be able to make a voluntary choice among the alternatives. These criteria apply to minors as well as adults.

### **Privacy and Confidentiality**

There are numerous reasons why it is important to maintain confidentiality in the delivery of health care services to adolescents. Possibly the most important is to encourage adolescents to seek necessary care, but additional reasons include supporting adolescents' growing sense of privacy and autonomy and protecting them from the humiliation and discrimination that could result from disclosure of confidential information.

The confidentiality obligation has numerous sources in law and policy. They include: the federal and state constitutions; federal statutes and regulations (such as those which pertain to Medicaid, Title X family planning programs, federal drug and alcohol programs, Title V maternal and child health programs, or community and migrant health centers); state statutes and regulations (such as medical confidentiality statutes, medical records statutes, privilege statutes, professional licensing statutes, or funding statutes); court decisions; and professional ethical standards.

Because these varied provisions sometimes conflict, or are less than clear in their application to minors, it is important that practitioners have some general guidelines to follow -- or questions to ask -- in developing their understanding how to handle confidential information. Confidentiality protections are rarely, if ever, absolute, so it is important for practitioners to understand what *may* be disclosed (based on their discretion and professional judgement), what *must* be disclosed, and what *may not* be disclosed. In reaching this understanding, a few of the most relevant questions include: What information is confidential (since it is confidential information that is protected against disclosure)? What information is not confidential (since such information is not protected)? What exceptions are there in the confidentiality requirements? What information can be released with consent? What other mechanisms allow for discretionary disclosure? What mandates exist for reporting or disclosing confidential information?

In general, even confidential information may be disclosed as long as authorization is obtained from the patient or another appropriate person. Often, when minors have the legal right to consent to their own care, they also have the right to control disclosure of confidential information about that care. This is not always the case, however, since there are a number of circumstances in which disclosure over the objection of the minor might be required: for example, if a specific legal provision requires disclosure to parents; a mandatory reporting obligation applies, as in the case of suspected physical or sexual abuse; or the minor poses a severe danger to himself or others.

When the minor does not have the legal right to consent to care, or to control disclosure, the release of confidential information must generally be authorized by the minor's parent or the person (or entity) with legal custody or guardianship. Even when this is necessary, however, it is still advisable -- from an ethical perspective -- for the practitioner to seek the agreement of the minor to disclose confidential information and certainly, at minimum, to advise the minor at the outset of treatment of any limits to confidentiality. Fortunately, in many circumstances, issues of confidentiality and disclosure can be resolved by discussion and information agreement between a physician, the adolescent patient, and the parents without reference to legal requirements.

### **Payment**

There is an integral relationship among the legal provisions which pertain to consent, confidentiality, and payment in the delivery of health care services to adolescents. To the extent that an adolescent does not have available a source of free care or access to insurance coverage, provisions which purport to enable adolescents to give their own consent for care and to obtain it on a confidential basis do not actually guarantee access. It may seem implicit that if a minor is authorized to consent to care, it is the minor rather than the parent who is responsible for payment and, in fact, some state statutes explicitly so provide. In reality, however, few if any adolescents are able to pay for health care. Consequently any legal provisions which make available to them free care or insurance coverage--such as eligibility requirements for Medicaid or policies which enable them to obtain confidential services from a managed care plan in which their family is enrolled -- are critical in ensuring their access to care . . . .

## I. The Basics

### C. Dilemmas in confidentiality in working with children and adolescents

#### 2. How to address confidentiality dilemmas and share information appropriately (cont.)

### **2c. Who Should Know What?**

#### **Confidentiality and Information Sharing in Service Integration**

Excerpted from: Early Head Start, National Resource Center

(<http://www.ehsnrc.org/InformationResources/ResourceArticles/ftconf.htm>)

Soler, M. & Peters, C. (1993). *Who should know what? Confidentiality and information sharing in service integration*. Des Moines, IA: National Center for Service Integration (pp. 5, and 12-19).

All too often, the services available to children and families at risk do not provide a close fit to what they actually need. These parents and children become defined by the labels they receive initially- "mentally ill," "delinquent," "abusive," or "drug dependent." They move into systems that provide limited individual services and ignore broader family issues. This single-issue approach often reduces the effectiveness of the services and misses the opportunity to address the underlying needs of clients in a comprehensive way. Their labels outlive their usefulness and prevent the development of effective services strategies. Different service systems may simultaneously or sequentially serve the same individuals without any coordination or continuity in service provision.

Recognizing this lack of coordination across service systems and the fragmentation and duplication of services it often creates, states and communities seek more integrated approaches that involve greater coordination and collaboration across different agencies and organizations serving children and families. Through interagency partnerships, states and communities hope to fill gaps in services, provide more service continuity and consistency, and reach beyond specific labels to provide more effective services for children and families.

These collaborations face many obstacles. One of the most commonly cited obstacles to interagency collaboration is the existence of confidentiality provisions that appear to restrict agencies from working together. Many professional view these limits on the flow of information - and potentially on the delivery of services - as major impediments to interagency collaboration. This resource brief proposes that confidentiality need not to a significant impediment to interagency collaboration. Based on the work in number of states and communities, several mechanisms exist for effective interagency information sharing that balance the interests of children and families (in protecting information from disclosure) with the interests of agencies who need to share information to work effectively. This brief draw from legal research, literature reviews, and extensive discussions with public officials and agency personnel who have addressed confidentiality concerns successfully. This brief does not aim to be a comprehensive analysis of confidentiality mandates or an exhaustive treatment of what any particular agency must do to satisfy those mandates. It is also not designed to help evade confidentiality provisions.

The interests of children and families in protecting private information from unauthorized disclosure are significant and should not be disregarded. The goal of this brief is to show that agencies can share information while respecting the rights and interests of children and families.

### **Ways to Facilitate Appropriate Information Sharing**

This Resource brief concurs with a larger Youth Law Center study of confidentiality provisions and interagency collaborations which concluded that agencies can successfully balance the privacy interests of clients and their own needs for information sharing and can find ways to share virtually all necessary information.

This chapter discusses how agencies can share needed information. Different agencies have different types of confidentiality requirements. These different requirements must be understood and balanced in order to share information across agencies. The first section discusses obtaining informed consent

to release information. The second reviews informal exchanges of information - information sharing authorized by statute, memoranda of understanding, interagency contracts, similar agreements, and court orders. The third discusses safeguards that agencies should employ to assure that information is not shared inappropriately. The final section covers special considerations when dealing with computerized information.

### **Informed Consent: Releases and Waivers**

Informed consent is the most common formal mechanism for exchanging information. The individual, who is the subject of the information, gives consent generally through a signed written release. When the person is legally incompetent, because of age for example, the parent or guardian may sign.

Federal statutes affecting children and families authorize disclosure of confidential information with consent. Privileges rooted in state law may also be waived with consent to release information. Some laws provide specific requirements for the consent to release information. For example, federal alcohol and drug abuse regulations are specific and include a sample release form. State laws stipulate requirements for release of certain kinds of information, such as HIV status and mental health information.

**Requirements of release.** Any release of personal information should be in writing. It should contain the following:

- The name of the person who is the subject of information.
- The name of the person, program, or agency sharing the information.
- The name of the person, program, or agency with whom the information will be shared.
- The reasons for sharing the information.
- The kind of information that will be shared.
- The signature of the person who is the subject of the information.
- The date the release is signed.
- A statement that the release can be revoked any time by the subject of the information.
- An expiration date for the release or a specific event (such as the end of the school year) that will terminate the release.
- A notice stating that the subject of information has a right to receive a copy of the release.

**Notices to clients.** Notices to clients of agency's need to release information are critical to the process of obtaining informed consent. These notices inform clients about the purpose and the extent of the consent being requested. Inadequate and confusing notices may mislead clients and impair the relationship between clients and service providers. Clearly presented notices can inform clients of their rights and help promote trust in the agency. Some statutes include specific requirements for notices to clients regarding the release of confidential information.

**Routines for obtaining releases.** It is good practice to obtain written releases from clients during initial interviews or as services begin. These releases should cover routine information. If the agency need additional information from the client later, it can obtain a supplemental release.

**Multiagency releases.** In Iowa, California, and other states, interagency collaborations have developed comprehensive release forms that satisfy the confidentiality mandates of the participating agencies. By signing one release form, the client permits the participating agencies to exchange information and to coordinate services for the client.

### **Obstacles to Making Consent Informed**

Consent to release confidential information must be "informed." The concept is analogous to consent to medical treatment. Generally, a client may give consent to release information in the same circumstances in which he or she may give consent to treatment: the person should possess sufficient knowledge of the risks and benefits of the release of information, and should be capable of making a reasoned choice between alternatives. The person should understand what information will be

disclosed, to whom it will be disclosed, the purpose of the disclosure, and the benefits of such disclosure.

Minors and legal "incompetency. " Even though minors are not legally allowed to make certain decisions, some state statutes provide that they may consent to release information. California, for example, allows minors to consent to and release information pertaining to certain types of health care, including care related to pregnancy, rape, sexually transmitted diseases, HIV/AIDS, and drug or alcohol abuse. Some states have "mature minor" rules under which minors found by a court to be sufficiently mature may consent to medical care and to the release of records. Some states allow minors who are legally emancipated, or who are themselves parents, to consent to care and the release of records.

Language and culture. Language and culture may compound the difficulties in obtaining informed consent. A written release of confidential information in a language not understood by the client is invalid. Some confidentiality statutes require that a notice of the consent, or the release form itself, be presented in the individual's native language. Agency personnel should also be aware of different cultural customs and attitudes about privacy. Many immigrants fear that the personal information they provide may put them or their families at risk of deportation. Whenever this is an issue, release forms should state clearly that no personal information will be given to the Immigration and Naturalization Service.

Consequences of refusing to give to consent. In most situations, if an agency worker explains the purposes and benefits of information sharing to a client, the client will consent to release information. If an agency needs the information to fulfill its own legal duties, it may be required to seek a court order to obtain the information. If an agency needs client information to provide additional services and the client initially refuses to allow for sharing of information to provide additional services and the client initially refuses to allow for sharing of information, the agency personnel should seek to show and convince clients that it is in their interest to allow sharing, and that sharing is essential to providing additional services.

**Penalty for violation.** Violations of confidentiality may result in criminal and civil liability on the part of the agency and the individual who releases the information. The agency may also face the loss of federal or other funds/. In practice, however, such penalties are quite rare because most information sharing benefits the client. Mistakes can occur, but the agency's beneficial intent is usually evident. Moreover, the initiation of formal proceedings may lead to an even wider disclosure of the information the client wishes to keep confidential. Only in the most unusual situations, in clear violation of applicable regulations, have clients sought relief under the penalty provisions of confidentiality statutes. The real force of confidentiality provisions is not in the legal penalties but in making it clear to agency workers that clients have legitimate interests in protecting personal information. Professionalism, ethics, and the tone set by agency administrators all play important roles in enforcing confidentiality provisions.

### **Other Methods of Sharing Information**

Information sharing authorized by statute and regulation. Most federal statutes permit disclosure of confidential information for a variety of administrative purposes without consent of the individual. An agency may share information for a number of reasons, including the following:

- Administration of the program or related programs.
- Audits
- Determinations of eligibility for services.
- Medical emergencies.
- Investigations, prosecutions, or civil or criminal proceedings related to program administration.

Authorized sharing of confidential information is common in state statutes. The statutes fall into several categories: broad authorizations for information sharing among agencies, specific authorizations regarding particular types of information (such as child abuse information), and



authorizations to share information to develop more comprehensive services for children and families (such as statutes that establish multidisciplinary teams to develop treatment plans).

**Interagency agreements and memoranda of understanding.** Under several federal and state statutes, agencies may enter into agreements to share information about clients to better achieve service goals. For example, federal regulations concerning alcohol and drug abuse authorize interagency information exchanges under a "qualified service organization agreement" (QSOA). Statutes in several states contain similar authorizations that allow agencies to share information without obtaining written releases from individual clients. Interagency agreements should specify:

*What* information will be shared.

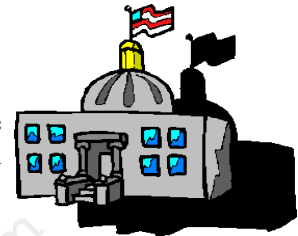
*How* the information will be shared.

*Who* will have access to the information.

The *purposes* for information sharing.

*Assurances* by the participating agencies that they will not disclose the information further except as dictated by the agreement, and that they will resist other efforts to obtain the information.

*Other requirements* mandated by applicable confidentiality provisions.



**Court orders.** In recent years some juvenile courts have issued orders to guide interagency sharing of information. These orders allow the routine disclosure of juvenile court information to designated county departments to assist case planning and treatment.

**Informal exchanges of information.** The most common way to share information among agencies is informal. It is usually verbal and by telephone. A probation officer may, for example, call a school counselor to find out whether a child is attending school, in compliance with terms of probation. This method of exchange occurs principally when people who need limited bits of information are familiar with each other and have developed a relationship of trust.

Despite the widespread use of this form of information sharing, it may not comply with statutory requirements. These informal exchanges frequently take place without consent or statutory authorization. If an agency participates in this form of information exchange, it should advise clients that such limited, informal information sharing may occasionally be necessary, and then determine whether the clients have objections to the practice.

The agency will be on safest legal grounds if it obtains voluntary consent, in written form, to the exchange of verbal information, and establishes clearly the types of information exchanges that will occur. Clients are most likely to consent to such information sharing if they know it will help the agency respond to them. While informal and verbal communications often do not result in any written records, they represent communications and therefore do come under confidentiality provisions.

### **Ensuring Compliance with Information Sharing and Confidentiality Provisions**

Whatever the procedures established for information sharing and confidentiality, it is up to agency workers to carry out those procedures. Agencies should strive to provide work places that foster respect for clients and their privacy.

The methods described below can help emphasize the importance of confidentiality and help meet confidentiality obligations.

**Gatekeepers.** Many agencies designate one individual to act as the "gatekeeper" of confidential information concerning agency clients. This person fields requests for confidential information. Often the gatekeeper is the agency counsel. Other agencies designate a "seasoned" employee with specialized training who develops experience with the confidentiality issue and becomes a local specialist. The gatekeeper's duties may include:

- Maintaining a library of confidentiality materials.



- Providing training for agency employees on confidentiality requirements.
- Responding to requests for information and maintaining records of requests and responses.
- Developing forms for information requests.
- Suggesting some changes in information management practices when appropriate.
- Assuring that records are secure from fire, theft, and other damage.

**Confidentiality oaths.** Several statutes require confidentiality oaths, particularly for researchers. Some agencies use these staff pledges of confidentiality to promote sensitivity to clients' interests in privacy. The confidentiality oaths are usually written and signed. They constitute promises to use information only for designated agency purposes, and not to disclose the information to any other person or agency unless specifically authorized.

**The importance of staff training.** To follow legal mandates and respect individuals' right to privacy, it is essential for agencies to establish thorough and ongoing programs of staff instruction. Staff training on confidentiality should include:

The reasons for ensuring confidentiality of information about children and families.

The specific information the agency needs.

The reasons why the agency needs the information.

The type of information the worker's agency will share with other agencies.

The purposes of information sharing among agencies.

The legal provisions, particularly federal and state statutes and regulations, applicable to the agency's work.

The importance of clearly explaining to clients why consent is essential.

The need for sensitivity to language and cultural issues.

The requirements of informed consent and the necessary elements for written releases.

The role of interagency agreements, court orders, and other mechanisms that facilitate interagency information sharing that does not require the consent of clients.

Special issues that arise from the use of automated management information systems.



## **Working With Computerized Information**

The greatest strength of the computer is also its greatest danger: all of the information in all of the files is potentially available to anyone with a computer terminal - all without the consent of the clients. Consequently, automated systems containing client information require more levels and types of security than nonautomated systems. This is particularly significant with today's rapid growth of technology. Most agency records will eventually be stored in computers. When one agency's records become linked on a computer network with another agency's records for the sharing of information, safeguards must be in place to assure that confidential information will not be disclosed improperly. In developing a computerized data system and using it effectively, agencies should go through the following steps:

- Determine the purpose of the system.
- Obtain the cooperation of all participating agencies.
- Develop thorough security procedures.
- Train staff carefully.
- Provide notices to clients.

**Determine the purpose of the system.** Automated data management may have several purposes. Some purposes focus on the systems providing services; these include researching needs for services in the community, reporting services provided by particular agencies, evaluating the effectiveness of services, assessing cost-effectiveness of services, and planning for the future. Other purposes focus on meeting the needs of individual clients; these include assisting in comprehensive

assessments of client needs, finding services in the community that can meet the client's needs, and tracking the cost of providing the services. Planners should determine the purposes of the system at the design stage because that decision will affect other aspects of the system - such as information accessibility, levels of security, and system usefulness to administrators, policymakers, and workers.

**Obtain the cooperation of all participating agencies.** The development of an automated system requires a high degree of cooperation among agencies. Agencies must agree on what kind of hardware and software they will use and how they will ensure compatibility. Agencies must also agree on how to identify people in the system (using a selected numerical code). Although these initial steps are rudimentary, they can be substantial obstacles for agencies. Beyond the issues of hardware and software compatibility and common client identifiers, agencies need to agree on many other issues - such as what information each agency will enter into the system, who will have access to the information in the system, how the information may be used by participating agencies, and which security measures will be instituted to protect confidentiality and the integrity of the system.

**Develop thorough security procedures.** Agencies should develop several levels of security to properly safeguard automated data systems:

*Security of the physical environment.* Data tapes and disks should remain in locked rooms when not in use. Access to these materials should be strictly controlled, with chain-of-custody controls on the people who move tapes and disks. Agencies should maintain logs for recording the location of all disks and tapes at all times. Access to computers tapped into the data should be strictly limited.

*Security of on-line data.* Once the information is stored in the computer system, agencies should limit access to it. This usually involves a series of passwords. Each password allows the user to get deeper into the system, depending on his or her authorization to have that level of information. Security is maintained if each user knows only the passwords that allow access to the information that the user has a legitimate need for. Some information may be so sensitive that agencies will prefer not to enter it into any computer database subject to access from outside agencies.

*Use of identifiers to mask personal identities.* Agencies should identify individuals whose information is in the system by codes, not by personal names. One of several identifiers could be used, including agency-assigned identifying numbers. Some systems have specialized methods for developing identifiers, such as using certain letters from the client's last name. In theory, only one person knows the true identity of the person, the person who enters the information initially into the computer and assigns an identifier. This technical breach of confidentiality is usually considered minor and inconsequential.

*Train staff carefully.* The importance of staff training in this area cannot be overstated. Automated systems make so much more confidential information potentially available to so many more workers that the need for regular and comprehensive training is much greater.

*Provide notices to clients.* Clients should receive notices stating that certain information about them is being recorded on an automated data system and that it will be accessible to others for specific purposes. The notice should specify the type of information entered into the system, the particular individuals or agencies who will have access to the information, the reasons for which they may have access to the information, and the uses they may make of the information. If the information can be shared among agencies, pursuant to a statutory provision or an interagency agreement, a general notice to this effect may be sufficient. If the information sharing requires the client's consent, the agencies could develop a common consent form that the client can sign only once.

Confidentiality provisions strike a balance between the interests of children and families in protecting information from disclosure and the interests of agencies in sharing information. By using the principles and mechanisms described in this brief, agencies should not find that confidentiality provisions significantly impede interagency collaboration. Many agencies both share information and respect the privacy interests of children and families.

## I. The Basics (cont.)

### C. Dilemmas in confidentiality in working with children and adolescents (cont.)

#### 2. How to address confidentiality dilemmas and share information appropriately (cont.)

### **2d. Critical Issue: Addressing Confidentiality Concerns in School-Linked Integrated Service Efforts**

Excerpted from: North Central Regional Educational Laboratory  
<http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs300.htm>  
see original article for cited references

**ISSUE:** Schools and human service agencies increasingly are working together to meet the multiple needs of children and families through school-linked integrated services. One of the most common implementation issues faced by these collaboratives is addressing the need to share information about the people they serve. When confronting multiple and often confusing confidentiality provisions, which place constraints on the exchange of information, many professionals view confidentiality as a barrier to the delivery of services and ultimately to interagency collaboration. Yet addressing confidentiality concerns and developing guidelines for sharing information are essential tasks for collaboratives. "Confidentiality is neither an impenetrable barrier nor something which can easily be disregarded," note Greenberg and Levy (1992); "it is possible to develop means of exchanging information that are effective and practical on a wide scale, while still respecting legitimate rights to privacy" (pp. 1-2).



**OVERVIEW:** Collaboratives linking students and schools to integrated services recognize the importance of collective endeavor in meeting the range of needs of families and children and in promoting positive youth development. When collaborating to meet their mutual goals and provide services to children and families more effectively, school staff and human service providers often need to share information on common clients. The sharing of this often-sensitive information, however, raises a number of ethical and legal issues relating to confidentiality.

Soler and Peters (1993) describe several ethical reasons for protecting the privacy of children and families when implementing school-linked services: Confidentiality provisions help protect families from embarrassing disclosures, discrimination against themselves or their children, differential treatment, and threats to family and job security. Confidentiality provisions also may encourage students or families to take advantage of services designed to help them (Constantine, Aronson & Wilber, 1994).

Many of the legal protections to confidentiality are constitutionally based in the fundamental right "to be let alone" (Soler & Peters, 1993, p. 6). Right-to-privacy protections also are reflected in federal and state statutes, statutory privileges, agency regulations, ethical standards, and professional practice standards (Soler & Peters, 1993, p. 9).

A 1974 federal law, the Family Educational Rights and Privacy Act (FERPA), protects the privacy interests of students in elementary and secondary schools (and their parents) with regard to certain types of education records. FERPA requires that prior consent be obtained from the student (if 18 or older) or the student's parents before certain types of information can be released from school records. FERPA also gives parents and students access to records, along with the right to challenge the accuracy of those records and make necessary modifications. Changes to FERPA most recently were enacted as part of the Improving Schools Act of 1994, resulting in the issuance of final regulations of FERPA by the U.S. Department of Education. These amendments help promote information sharing by educators (Laney, 1996).

While FERPA legislates the sharing of education records, other federal statutes and regulations govern confidentiality of other types of information; these statutes and the regulations implementing them may affect the ability of health and social service agencies to share information with schools. In addition, service providers often adhere to formal or informal codes of professional ethics that influence their willingness to share information (Greenberg & Levy, 1992; Larson, 1992). For example, the American Psychological Association (1992) includes a section on Privacy and Confidentiality in its Ethical Principles of Psychologists and Code of Conduct. Similarly, the National Association of Social Workers (1996) has a section on Privacy and Confidentiality in the Ethical Standards section of its Code of Ethics. All these issues must be considered when schools and service agencies collaborate for information sharing.

As part of their implementation efforts for school-linked services, schools and service agencies may convene a collaborative team that is charged with addressing confidentiality concerns, protecting the privacy of student records, and developing guidelines for information sharing. Because educators, service agencies, and individual service providers may have different perspectives and professional obligations with regard to confidentiality (Office of Educational Research and Improvement, 1996), specific confidentiality concerns should be temporarily set aside until team members have developed a comfortable working relationship. At initial meetings, emphasis should be placed on a common basis of understanding and a shared commitment to the importance of information sharing (Greenberg & Levy, 1992).

After a sense of trust has developed, collaborative partners are ready to discuss the implications of confidentiality for their work together. Partners determine who to involve in the information-sharing process, clarify reasons to share information, identify and address legal issues relating to confidentiality, and identify and address nonlegal issues that may present barriers to information sharing (Greenberg & Levy, 1993).

At this point, collaborating partners will need to review existing statutes, regulations, and court decisions that clarify the laws regarding confidentiality; determine types of data to share and for what purpose; decide how information will be stored; and specify who will have access. Special attention should be paid to information sharing between schools and the juvenile justice system when juvenile delinquency is involved. The partners then can establish policies and procedures for sharing information that balance the legal and ethical privacy rights of individuals and the partners' needs to share information on common clients. The development of policies and procedures for the exchange of information should involve at least one attorney (Greenberg & Levy, 1992).

Next, partners need to determine a method for obtaining informed consent to share client information. The most common method for obtaining this information is through a release form, which is signed by the client or by the parent/guardian if the student is a legal minor. In some special situations involving the provision of medical services to students, however, adolescents may sign the release form.

Partners need to decide whether each agency will use its own release form or if a common release form will be developed for the collaborative (Soler & Peters, 1993; Greenberg, 1992). In addition to developing release forms, partners need to develop procedures for presenting the release form and obtaining consent from clients. Also to be designed is a systematic way to keep clients continually informed about what information will be shared, with whom, and for what purpose. Partners then should educate themselves regarding the circumstances under which information may be shared without prior consent, particularly when there is duty to warn in order to protect an individual's health or safety.

Determining security procedures for maintaining records and information is another important task for the collaborative. Schrier (1980) suggests that every agency "designate responsibility for managing its record system to an individual and institute such safeguards to security as locked files and requirements for verifying the identity of persons releasing and requesting information" (p. 455). Because client information typically is maintained on computer databases, agencies should develop

security procedures to safeguard automated data so that confidential information is not disclosed improperly. Greenberg and Levy (1992) suggest that service providers should consider limiting the data in the system and the data that can be retrieved from the system. Partners also need to develop a system for documenting the disposition of requests to release information.

Everyone on the staff of schools that are part of collaboratives needs to understand confidentiality requirements. The professional development and support opportunities provided by schools should help school staff develop awareness of confidentiality requirements and procedures as well as sensitivity to client needs for privacy.

Resolving confidentiality issues when sharing client and family information has been identified as one of the major factors essential to successful implementation of collaborative school-linked service efforts (Wang, Haertel & Walberg, 1995). But when collaboratives are armed with an understanding of the power of sharing information as well as the ethical and legal ramifications of doing so, they should be able to create information-sharing policies and procedures that will enable them to serve children and families more effectively while protecting privacy rights.

### **GOALS:**

- Collaborative partners reach consensus concerning what information needs to be shared, reasons for sharing that information, and reasons for protecting the privacy of children and families.
- Each client's right to privacy is balanced with the organization's need to share information and effectively serve the client.
- School and agency staff, working with an attorney, are sensitive to clients' rights and knowledgeable about related confidentiality laws, liability issues, and procedures.
- Procedures are in place to guarantee that confidentiality will be upheld.
- Clients are kept informed continually of what information will be shared, with whom, and for what purpose.

**ACTION OPTIONS:** When a school is part of an integrated services collaborative, school staff and the collaborative team can take the following steps to coordinate efforts so that confidentiality issues are addressed and guidelines for sharing information are used effectively.

### **School Staff (including administrators, teachers, social workers, nurses, psychologists, counselors, library media specialists, and support personnel):**

- Learn about confidentiality and information sharing in service integration.
- Participate in professional development and support to become aware of confidentiality requirements and procedures, the client's right to privacy, and the ramifications of refusal to give consent.

### **Collaborative Team (comprising educators, service providers, high-level education and agency officials, parents, community members, legislators and judges, attorneys, and management information system staff):**

- Allow time to develop a working relationship with service agencies and establish a shared commitment to mutual goals before discussing confidentiality issues.
- Discuss implications of confidentiality and agree upon what information needs to be shared, types of data to share, reasons for sharing information, and reasons for protecting the privacy of children and families.



- Seek legal advice during the process of reviewing federal statutes and regulations, court decisions, agency regulations, and state regulations concerning confidentiality, as well as confidentiality provisions relating to substance-abuse treatment and testimony in court. (The school librarian or library media specialist can help locate copies of laws and regulations.)
- Develop awareness of nonlegal issues that may present barriers to information sharing.
- Follow guidelines for protecting the privacy of student records.
- Determine the feasibility of developing a common release form that can be used by all agencies.
- Develop procedures for presenting the release form and obtaining consent.
- Develop procedures to inform students and families of their rights. (The final regulations of FERPA include A Model Notification of Rights Under FERPA for Elementary and Secondary Institutions.)
- Create procedures to ensure that clients are kept informed continually of all releases of information, including what will be shared, with whom, and for what purpose.
- Determine policies for sharing information based on available standards for data exchange and case management information systems to facilitate the exchange of information, reduce duplication of data entry, and ensure adherence to confidentiality standards.
- Determine the purpose of information maintained on computer databases as well as security procedures to safeguard automated data.
- Create or adapt procedures to protect confidentiality and strategies for protecting the confidentiality of information used across agencies.
- Keep documentation of each request for client information and any client information actually released.

**IMPLEMENTATION PITFALLS:** One of the major pitfalls encountered by collaborative partners is tackling issues of confidentiality before trust has been developed within the collaborative. Greenberg and Levy (1992) note:

"Working on confidentiality and information sharing should not be among the first tasks of a developing collaborative effort. Because the subject is complex and a mutually agreed upon approach for sharing is likely to entail compromises, it is important to have working relationships and commitment to joint efforts already firmly in place. The stronger the personal relationships among participants, the more easily confidentiality issues can be addressed. Holding off a bit on the time when the issue is tackled allows a base of trust, mutual understanding, and experience working together to be built." (p. 7).

Another pitfall is that participating institutions and agencies may be reluctant to share information with other agencies because of "feared loss of turf control, distrust of other professionals' use of confidential information, and ethical and legal concerns (including fear of lawsuits) when information leaves traditionally closed systems" (Crowson & Boyd, 1995). Some agencies even may withhold client information. To address these issues, collaboratives must emphasize the importance of trust and communication among partner members. Hendrickson and Omer (1995) state:

"While confidentiality must be ensured, a priority of comprehensive service schools should be to improve communication within and between agencies, work to change conditions that impede information sharing, and monitor the communication process continuously." (p. 159)

A third pitfall is laws that impede the sharing of information. Such laws often can be altered by legislative action to ease the process of sharing information without substantively changing existing protections. Sometimes laws affecting different agencies are inconsistent, perhaps simply because



they were adopted at different times by different drafters. After reviewing such laws, legislators may act to reduce these inconsistencies, making it easier for collaborating agencies to adopt common procedures (Greenberg & Levy, 1992, p. 29).

Interpretations of laws also can impede the sharing of information. According to Laney (1996), educators may interpret FERPA restrictively and then develop correspondingly restrictive confidentiality policies:

"Many state and local educational agencies and institutions have been overly restrictive in their interpretation of FERPA or in their information release policies. Educators frequently decide to err on the side of caution by establishing policies recognizing a generalized right to privacy with regard to all information on students. Unfortunately, both inaccurate interpretations and restrictive FERPA policies pose significant obstacles to meaningful information sharing between agencies." (p. 1)

The rural or urban setting of the school may contribute to other pitfalls. A rural culture, for example, may pose difficulties for educators and service providers who need to distinguish clearly between their personal and professional roles and their respective sanctions. An urban culture may contribute to overly informal sharing of information that does not adhere to confidentiality guidelines.

There are rare instances when a parent or student does not want to give consent. In these situations, the counselor or service provider should try to determine, without putting pressure on the individual, why the person is refusing to give consent and then seek review of this concern by the involved partners. One approach is to hold an interagency team meeting in which a caseworker presents information about the nonconsenting individual or family but withholds all identifying information so that it is a generic case. With this approach, the caseworker can receive the group's consideration and advice without breaching confidentiality (Greenberg & Levy, 1992). Some confidentiality statutes provide for duty to warn, or sharing information when necessary to protect the health or safety of an individual in an emergency situation.

**DIFFERENT POINTS OF VIEW:** Some stakeholders believe that sharing a client's personal information with service providers is not really breaching confidentiality but is a means of providing needed services effectively and efficiently to the client.

Others may believe that information should never be shared among service providers because of the possibility for leaks of potentially damaging information, particularly when computers are used to store personal information about clients.

### ILLUSTRATIVE CASES

The following examples illustrate how several programs of school-linked integrated services have approached confidentiality.

Confidentiality Issues at Fulton County Schools, Hickman, Kentucky  
(<http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs3lk31.htm>)

Confidentiality Issues at New Beginnings Center for Children and Families, San Diego, California  
(<http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs3lk11.htm>)

Confidentiality Guidelines of Youth Services Teams, Linn County, Oregon  
(<http://www.ncrel.org/sdrs/areas/issues/envrnmnt/css/cs3lk37.htm>)

## II. Guidelines regarding confidentiality

### A. Policy / Law / Ethics

#### 1. Health Information Portability and Accountability Act

HHS Fact Sheet, US Department of Health and Human Services, Press office (202)690-6343

April 14, 2003 <http://www.hhs.gov/news/facts/privacy.html>

## PROTECTING THE PRIVACY OF PATIENTS' HEALTH INFORMATION

**Overview:** *The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.*

*Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect*

*the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. Most health insurers, pharmacies, doctors and other health care providers were required to comply with these federal standards beginning April 14, 2003. As provided by Congress, certain small health plans have an additional year to comply. HHS has conducted extensive outreach and provided guidance and technical assistance to these providers and businesses to make it as easy as possible for them to implement the new privacy protections. These efforts include answers to hundreds of common questions about the rule, as well as explanations and descriptions about key elements of the rule. These materials are available at <http://www.hhs.gov/ocr/hipaa>*

### PATIENT PROTECTIONS

The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable

health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access To Medical Records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.
- **Notice of Privacy Practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14 and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.
- **Limits on Use of Personal Medical Information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.
- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- **Stronger State Laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.
- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.
- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices. Consumers can find out more information about filing a complaint at <http://www.hhs.gov/ocr/hipaa> or by calling (866) 627-7748.

## HEALTH PLANS AND PROVIDERS

The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures.** The rule requires covered entities to have written privacy procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.
- **Employee Training and Privacy Officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.
- **Public Responsibilities.** In limited circumstances, the final rule permits -- but does not require -- covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.
- **Equivalent Requirements For Government.** The provisions of the final rule generally apply equally to private sector and public sector covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

## OUTREACH AND ENFORCEMENT

HHS' Office for Civil Rights (OCR) oversees and enforces the new federal privacy regulations. Led by OCR, HHS has issued extensive guidance and technical assistance materials to make it as easy as possible for covered entities to comply with the new requirements. Key elements of OCR's outreach and enforcement efforts include:

- **Guidance and technical assistance materials.** HHS has issued extensive guidance and technical materials to explain the privacy rule, including an extensive, searchable collection of frequently asked questions that address major aspects of the rule. HHS will continue to expand and update these materials to further assist covered entities in complying. These materials are available at <http://www.hhs.gov/ocr/hipaa/assist.html>
- **Conferences and seminars.** HHS has participated in hundreds of conferences, trade association meetings and conference calls to explain and clarify the provisions of the privacy regulation. These included a series of regional conferences sponsored by HHS, as well as many held by professional associations and trade groups. HHS will continue these outreach efforts to encourage compliance with the privacy requirements.

- **Information line.** To help covered entities find out information about the privacy regulation and other administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, OCR and HHS' Centers for Medicare & Medicaid Services have established a toll-free information line. The number is (866) 627-7748.
- **Complaint investigations.** Enforcement will be primarily complaint-driven. OCR will investigate complaints and work to make sure that consumers receive the privacy rights and protections required under the new regulations. When appropriate, OCR can impose civil monetary penalties for violations of the privacy rule provisions. Potential criminal violations of the law would be referred to the U.S. Department of Justice for further investigation and appropriate action.
- **Civil and Criminal Penalties.** Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, OCR may impose monetary penalties up to \$100 per violation, up to \$25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain actions such as knowingly obtaining protected health information in violation of the law. Criminal penalties can range up to \$50,000 and one year in prison for certain offenses; up to \$100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to \$250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.



## II. Guidelines Regarding Confidentiality (cont.)

### A. Policy / Law / Ethics (cont.)

#### 2. Family Educational Rights and Privacy Act (FERPA)

<http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>

Get the Latest on FERPA at [familypolicy.ed.gov](http://familypolicy.ed.gov) <http://familypolicy.ed.gov/?src=ferpa>

- Frequently Asked Questions  
<http://familypolicy.ed.gov/faq-page?src=ferpa>
- FERPA for parents and students and school officials  
<http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>
- Protection of Pupil Rights Amendment (PPRA)  
<http://familypolicy.ed.gov/ppra?src=ferpa>
- Guidance and Notices  
<http://familypolicy.ed.gov/content/ferpa-school-officials-guidance-and-notices?src=ferpa>

#### Family Policy Compliance Office (FPCO) Home

<http://www2.ed.gov/policy/gen/guid/fpco/index.html>

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

- Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.
- Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.
- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):
  - >School officials with legitimate educational interest;
  - >Other schools to which a student is transferring;
  - >Specified officials for audit or evaluation purposes;
  - >Appropriate parties in connection with financial aid to a student;
  - >Organizations conducting certain studies for or on behalf of the school;



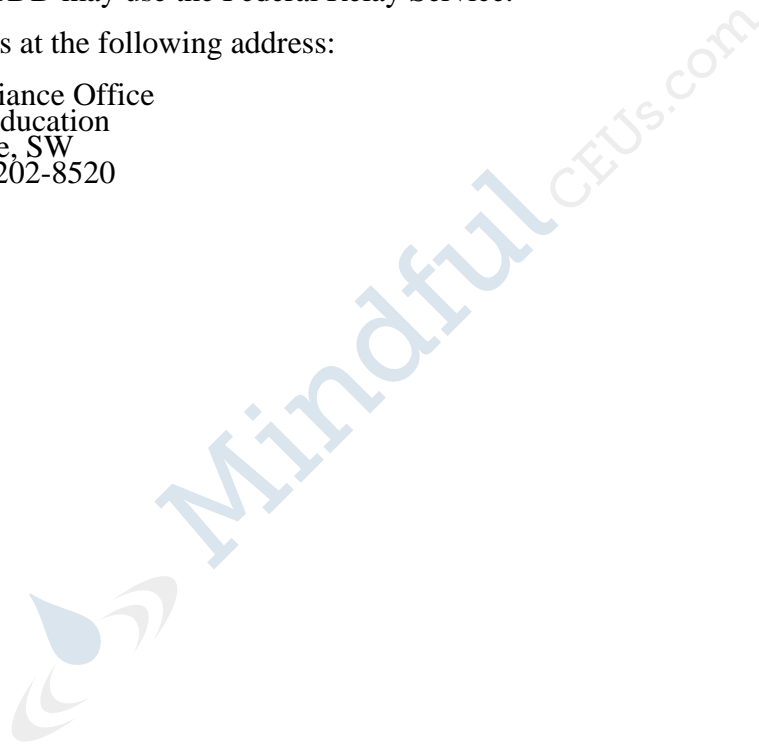
- >Accrediting organizations;
- >To comply with a judicial order or lawfully issued subpoena;
- >Appropriate officials in cases of health and safety emergencies; and
- >State and local authorities, within a juvenile justice system, pursuant to specific State law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.

For additional information, you may call 1-800-USA-LEARN (1-800-872-5327) (voice). Individuals who use TDD may use the Federal Relay Service.

Or you may contact us at the following address:

Family Policy Compliance Office  
U.S. Department of Education  
400 Maryland Avenue, SW  
Washington, D.C. 20202-8520



## II. Guidelines Regarding Confidentiality (cont.)

### A. Policy / Law / Ethics (cont.)

#### **3. What Parents Need to Know About Confidentiality**

<http://schoolcounselor.org/magazine/blogs/January-February-2008/what-parents-need-to-know-about-confidentiality>

When it comes to their children meeting with a school counselor, some parents are reluctant to support such a decision. They may fear the child will share “family secrets,” which will then be spread throughout the school. Or that all the teachers in the faculty lounge will learn of their child’s specific problems and hold it against the student.

In fact, such concerns couldn’t be further from the truth.

A student’s right to privacy and confidentiality is the basis for an effective counseling relationship. Confidentiality ensures that school counselors won’t share students’ disclosures with others except when the student authorizes it or when there is a clear and present danger to the student and/or to other persons.

And, should parents to be called in to meet with the school counselor as well, in a collaborative effort to help the student, parents must also realize that confidentiality is the hallmark of a school counselors’ work. When students enter into a counseling relationship with their school counselor, the school counselor will educate the student about the purposes, goals, techniques and rules of procedure under which they may receive counseling. This disclosure notice, which the school counselor will explain in terms appropriate to the student’s age and cognitive ability, addresses the limits of confidentiality, such as the possible need to consult with other professionals, privileged communication, and legal or authoritative restraints. Consulting with other professionally competent persons is essential in the school setting when this is in the student’s best interest. The parents/guardians are informed of the confidential nature of the counseling relationship between the counselor and student. Information is kept confidential unless disclosure is required to prevent clear and imminent danger to the student or others, or when legal requirements demand that confidential information be revealed.

As counseling with a student progresses, it may become beneficial or necessary for the school counselor to consult and collaborate with parents. Either the parent or the professional school counselor may initiate the collaboration process. It’s the school counselor’s responsibility to reach an agreement with the student about what information to share with the parents. Unless, of course, there is a clear and imminent danger to the student or others.

The school counselor and parents need to build a relationship of mutual respect and trust to make the best decisions about the child. Trust means that what is shared is confidential and related to the child. The relationship between parent and school counselor develops through working together. With a primary obligation to the student, confidentiality is balanced with an understanding of the parents’ legal and inherent rights to be the guiding voice in their children’s lives.

While respecting the rights and responsibilities of parents/guardians for their children, the school counselor works to establish a mutual relationship with parents/guardians to maximize a student’s development. In addition, school counselors respect students’ values and beliefs without imposing their own personal values on the situation. School counselors also adhere to laws, local guidelines and ethical standards of practice when assisting

parents/guardians experiencing family difficulties interfering with a student's effectiveness and welfare. School counselors are sensitive to diversity among families and recognize that all parents/guardians, custodial and noncustodial, have certain rights and responsibilities for their children's welfare. School counselors also make reasonable efforts to honor the wishes of parents/guardians concerning information regarding the student, and, in cases of divorce or separation, exercise a good-faith effort to keep both parents informed with regard to critical information, with the exception of a court order.

Confidentiality is limited and is much more difficult to guarantee in group counseling than in individual counseling. Group counseling, which involves a number of students working on shared tasks and developing supportive relationships in a group setting, presents different issues. Group counseling is an efficient way of to deal with students' problems and concerns, allowing individuals to develop insights into themselves and others. However, confidentiality is much more difficult to maintain, and school counselors will disclose these limitations as part of the group counseling process.

The limitations of confidentiality don't include information of possible abuse or harm to a child. By law, school counselor must report any case of abuse or neglect to the appropriate authorities. School counselors inform parents/guardians or appropriate authorities when a student's condition indicates a clear and imminent danger to the student or others. This is done after careful deliberation and, where possible, after consulting with other counseling professionals. The school counselor will attempt to minimize the threat to a student and may choose to: 1) inform the student of actions to be taken, 2) involve the student in a three-way communication with parents/guardians when breaching confidentiality or 3) allow the student to have input as to how and to whom the breach will be made.

Confidentiality of information received in the counseling relationship is protected to some degree by federal and state laws, policies and ethical standards. Counselors have a responsibility to protect the privileged information received through confidential relationships with students, parents or guardians and with staff. Such information is only to be revealed to others with the student's informed consent, consistent with the school counselor's ethical obligation. In some situations, school counselors must also respond when subpoenaed in court. If reports are required, the school counselor makes every effort to limit information to what is relevant to the legal proceedings.

Student records and release of personal data is protected under confidentiality in accordance with prescribed laws and school policies. Student information stored and transmitted electronically is treated with the same care as traditional student records.

Confidentiality of records and access to confidential information is a concern of school counselors. School counselors have a responsibility to maintain the confidentiality of records and encourage school administrators to develop written policies concerning the ethical and legal handling of all records in their school system.

Brenda Melton, LPC, NBCT, is the lead counselor at Lanier High School in San Antonio, Texas, and can be reached at [meltonbrenda@msn.com](mailto:meltonbrenda@msn.com).

II. Guidelines Regarding Confidentiality (cont.)  
A. Policy / Law / Ethics (cont.)

**4. U.S. Department of Education Guide**

<http://www.ed.gov/policy/gen/guid/fpco/brochures/elsec.html>

**Balancing Student Privacy and School Safety: A Guide to the**

***Family Educational Rights and Privacy Act for Elementary and Secondary Schools***

School officials are regularly asked to balance the interests of safety and privacy for individual students. While the *Family Educational Rights and Privacy Act (FERPA)* generally requires schools to ask for written consent before disclosing a student's personally identifiable information to individuals other than his or her parents, it also allows schools to take key steps to maintain school safety. Understanding the law empowers school officials to act decisively and quickly when issues arise.

**HEALTH OR SAFETY EMERGENCY**

In an emergency, *FERPA* permits school officials to disclose without consent education records, including personally identifiable information from those records, to protect the health or safety of students or other individuals. At such times, records and information may be released to appropriate parties such as law enforcement officials, public health officials, and trained medical personnel. *See* 34 CFR §§ 99.31(a)(10) and §§ 99.36. This exception is limited to the period of the emergency and generally does not allow for a blanket release of personally identifiable information from a student's education records.

**LAW ENFORCEMENT UNIT RECORDS**

Many school districts employ security staff to monitor safety and security in and around schools. Some schools employ off-duty police officers as school security officers, while others designate a particular school official to be responsible for referring potential or alleged violations of law to local police authorities. Under *FERPA*, investigative reports and other records created and maintained by these "law enforcement units" are not considered "education records" subject to *FERPA*. Accordingly, schools may disclose information from law enforcement unit records to anyone, including outside law enforcement authorities, without parental consent. *See* 34 CFR §§ 99.8.

While a school has flexibility in deciding how to carry out safety functions, it must also indicate to parents in its school policy or information provided to parents which office or school official serves as the school's "law enforcement unit." (The school's notification to parents of their rights under *FERPA* can include this designation. As an example, the U.S. Department of Education has posted a model notification on the Web at: <http://www.ed.gov/policy/gen/guid/fpco/ferpa/lea-officials.html> .)

Law enforcement unit officials who are employed by the school should be designated in its *FERPA* notification as "school officials" with a "legitimate educational interest." As such, they may be given access to personally identifiable information from students' education records. The school's law enforcement unit officials must protect the privacy of education records it receives and may disclose them only in compliance with *FERPA*. For that reason, it is advisable that law enforcement unit records be maintained separately from education records.

**SECURITY VIDEOS**

Schools are increasingly using security cameras as a tool to monitor and improve student safety. Images of students captured on security videotapes that are maintained by the school's law

enforcement unit are not considered education records under *FERPA*. Accordingly, these videotapes may be shared with parents of students whose images are on the video and with outside law enforcement authorities, as appropriate. Schools that do not have a designated law enforcement unit might consider designating an employee to serve as the "law enforcement unit" in order to maintain the security camera and determine the appropriate circumstances in which the school would disclose recorded images.

## **PERSONAL KNOWLEDGE OR OBSERVATION**

*FERPA* does not prohibit a school official from disclosing information about a student if the information is obtained through the school official's personal knowledge or observation, and not from the student's education records. For example, if a teacher overhears a student making threatening remarks to other students, *FERPA* does not protect that information, and the teacher may disclose what he or she overheard to appropriate authorities.

## **TRANSFER OF EDUCATION RECORDS**

Finally, under *FERPA*, school officials may disclose any and all education records, including disciplinary records and records that were created as a result of a student receiving special education services under Part B of the *Individuals with Disabilities Education Act*, to another school or postsecondary institution at which the student seeks or intends to enroll. While parental consent is not required for transferring education records, the school's annual *FERPA* notification should indicate that such disclosures are made. In the absence of information about disclosures in the annual *FERPA* notification, school officials must make a reasonable attempt to notify the parent about the disclosure, unless the parent initiated the disclosure. Additionally, upon request, schools must provide a copy of the information disclosed and an opportunity for a hearing. See 34 CFR §§ 99.31(a)(2) and §§ 99.34(a).

## **Contact Information**

While the education agency or institution has the responsibility to make the initial, case-by-case determination of whether a disclosure is necessary to protect the health or safety of students or other individuals, U.S. Department of Education staff members are available to offer assistance in making this determination. For further information about *FERPA*, contact the Department's Family Policy Compliance Office.

Family Policy Compliance Office  
U.S. Department of Education  
400 Maryland Ave. S.W.  
Washington, DC 20202-5920  
Tel#: 202-260-3887

For quick, informal responses to routine questions about *FERPA*, parents may also e-mail the Family Policy Compliance Office at [FERPA.Customer@ED.Gov](mailto:FERPA.Customer@ED.Gov).

For inquiries about *FERPA* compliance training, e-mail [FERPA.Client@ED.Gov](mailto:FERPA.Client@ED.Gov).

Additional information and guidance may be found at FPCO's Web site at: <http://www.ed.gov/policy/gen/guid/fpc/index.html>.

II. Guidelines Regarding Confidentiality (cont.)  
B. Professional Association Policy Statements

***1. American Academy of Pediatrics: Policy Statement  
Confidentiality in Adolescent Health Care (RE9151)***

<http://www.aap.org>

*This statement was approved as policy by the following organizations: the American Academy of Pediatrics; the American Academy of Family Physicians; the American College of Obstetricians and Gynecologists; NAACOG-The Organization for Obstetric, Gynecologic, and Neonatal Nurses; and the National Medical Associations.*

**A**dolescents tend to underutilize existing health care resources. The issue of confidentiality has been identified, by both providers and young people themselves, as a significant access barrier to health care.

Adolescents in the United States, while generally considered healthy, have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities and even their lives. To illustrate, there is an urgent need to reduce the incidence of adolescent suicide, substance abuse, and sexually transmitted diseases and unintended pregnancy.

As the primary providers of health care to adolescents, we urge the following principles for the guidance of our professional members and for broad consideration in the development of public policy:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.
2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:
  - \* The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.
  - \* The adolescent must understand under what circumstances (eg, life-threatening emergency), the provider will abrogate this confidentiality.
  - \* Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.
4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescent are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care.



## II. Guidelines Regarding Confidentiality (cont.)

### B. Professional Association Policy Statements (cont.)

#### **2. School Social Workers Association of America Resolution Statement on Confidentiality**

<http://c.ymcdn.com/sites/www.sswaa.org/resource/resmgr/imported/School%20Social%20Workers%20and%20Confidentiality.pdf>

#### **Introduction:**

Standards of practice for school social workers require that "adequate safeguards for the privacy and confidentiality of information" be maintained. Confidentiality is an underlying principle of school social work and is essential to the establishment of an atmosphere of confidence and trust between the professionals and the individuals they serve.

Information is communicated to school social workers by students and families with the expectation that these communications will remain confidential. An assurance of confidentiality promotes the free disclosure of information necessary for effective treatment.

#### **Ethical and Legal Responsibilities:**

*Direct Services:* Providing services to students in the school setting requires a careful balance between legal and ethical responsibilities. School social workers must be conversant with federal, state, and local laws and policies governing confidentiality. School social workers must follow the guidelines established by the state and school district in which they work, recognizing that those guidelines may differ from those governing private practice.

Most states recognize that communications between social worker and client are privileged; however, this privilege is not absolute. School social workers as members of a team of professionals may be confronted with situations where disclosure of information is critical to providing assistance to the student and family. It is the school social worker's obligation to obtain informed consent, i.e., explain the limitations on confidentiality to the student and family, prior to service delivery.

Information should be shared with other school personnel only on a need-to-know basis and only for compelling professional reasons. Prior to sharing confidential information, school social workers should evaluate the responsibility to and the welfare of the student. The responsibility to maintain confidentiality also must be weighed against the responsibility to the family and the school community. However, the focus should always be on what is best for the student. School social workers must be conversant with affirmative reporting requirements. All states now require school professionals to report suspected cases of child abuse and neglect.

School social workers should be aware of school board policies and should ensure that such policies safeguard confidentiality of the reporting individual. School social workers should familiarize themselves with school board policies and state and local laws governing reporting requirements for students who are HIV-positive or have AIDS.

School social workers should also be aware of state statutes providing confidentiality to minor students who seek treatment for sexually transmitted diseases, information about and access to birth control, and pregnancy-related health care and counseling.

Therapists, including social workers, are under an affirmative duty to warn if there is a clear and present danger to the student or another identifiable individual. The social worker must warn any individual threatened by the student and must take steps to ensure the safety of a student who threatens suicide.

In all instances, school social workers must weigh the consequences of sharing information and must assume responsibility for their decisions.

*Written Material:* School social workers must be conversant with federal, state, and local laws and policies regarding confidentiality of and access to education records. Education records are all records which contain information directly related to a student and which are maintained by the educational agency or institution. Parents have the right to inspect and review education records. Social workers' personal notes kept for use by only those individuals are not considered education records and are confidential.

School social workers should inform students and parents that information gathered under the individualized education program (IEP) process may be shared with all members of the IEP team. The team, which includes other school personnel and the parents, may use the social history compiled by the school social worker in making decisions about the student's educational program and placement.

Documents maintained on a computer become education records if shared orally with another staff person. Sole possession records maintained on a computer are not considered part of the education record and are confidential. School social workers should also be aware that other staff members or computer technicians may have access to school-owned equipment. Saving sole possession records to an individual diskette and securing that diskette may provide greater assurance of confidentiality.

Confidential reports should be transmitted by facsimile only when absolutely necessary. Such reports should include a notation indicating that the material is confidential and is for professional use by only the designated recipient. The notation should also indicate that review, dissemination, distribution, or copying of the facsimile is prohibited.

**Conclusion:** The school social worker must carefully weigh the decision whether to preserve the confidentiality of information or to share the information, using the best interests of the student as a guide. Those decisions must be informed by federal, state, and local laws and policies, as well as the professional ethics of the school social worker.

**Endnotes:**

1. Standard 14, NASW Standards for School Social Work Services, June 1992.
2. NASW Commission on Education Position Statement: The School Social Worker and Confidentiality.
3. Privileged communications are statements made by persons in a protected relationship, which are legally protected from disclosure on the witness stand. The privilege is exercised by the client, and the extent of the privilege is governed by state statutes. H.C. Black, Black's Law Dictionary, Fifth Edition (1979).
4. NASW Position Statement.
5. Tarasoff v. Regents of the Univ. of Calif., 17 Cal. 3d 425, 1551 P.2d 334 (1976).
6. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 (1997). 7. IDEA, § 1412(a)(4).

School Social Work Association of America. (2001). School social workers and confidentiality.

Approved by the SSWAA Board of Directors on March 15, 2001

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## II. Guidelines regarding confidentiality (cont.)

### B. Professional Association Policy Statements (cont.)

#### **3. American School Counselor Association (ASCA)** **Position Statement: Confidentiality**

<http://www.schoolcounselor.org/content.asp?contentid=198>



#### **The Professional School Counselor and Confidentiality** **American School Counselor Association (ASCA) Position**

The professional responsibility of school counselors is to fully respect the right to privacy of those with whom they enter counseling relationships. Professional school counselors must keep abreast of and adhere to all laws, policies and ethical standards pertaining to confidentiality. This confidentiality must not be abridged by the counselor except when there is clear and present danger to the student and/or other persons.

**The Rationale:** Confidentiality is an ethical term denoting a counseling practice relevant to privacy. Privileged communication is a legal term denoting a requirement to protect the privacy between counselor and student.

A student has the right to privacy and confidentiality. ASCA recognizes that a counseling relationship requires an atmosphere of trust and confidence between the student and the counselor. Confidentiality ensures that disclosures will not be divulged to others except when authorized by the student or when there is a clear and present danger to the student and/or to other persons.

ASCA members affirm their belief in the individual's worth and dignity. It is the professional responsibility of school counselors to fully respect the right to privacy of those with whom they enter counseling relationships.

**The Professional School Counselor's Role:** Counselors have a responsibility to protect the privileged information received through confidential relationships with students, the students' parents or guardians and with staff. The professional school counselor reserves the right to consult with other professionally competent persons when this is in the student's best interest. In the event of possible judicial proceedings, the professional school counselor should initially advise the school administration and the counselee, and if necessary, consult with legal counsel. If reports are required, every effort should be made to limit demands for information to those matters essential for the purpose of the legal proceedings. When a professional counselor is in doubt about what to release in a judicial proceeding, the professional school counselor should arrange a conference with the judge to explain the dilemma and get advice as to how to proceed. Counseling information used in research and counselor training should fully guarantee counselees' anonymity.

It is the counselor's responsibility to provide notice to students regarding the possible necessity for consulting with others. This confidentiality must not be abridged by the professional school counselor except where there is a clear and present danger to the student and/or to other persons.

The professional school counselor and student should be provided with adequate physical facilities to guarantee the confidentiality of the counseling relationship. With the enactment of the Family Educational Rights and Privacy Act, P.L. 93-380 (The Buckley Amendment), great care should be taken with recorded information. All professional school counselors should have a copy of the complete law. Professional school counselors must adhere to P.L. 93-380; they must be concerned about individuals who have access to confidential information. It should be each school's policy to guarantee adequate working space for secretaries so that students and school personnel will not come into contact with confidential information, even inadvertently. Professional school counselors should undertake a periodic review of information requested of their students. Only relevant information should be retained. Professional school counselors will adhere to ethical standards and local policies in relating student information over the telephone. They have a responsibility to encourage school administrators to develop written policies concerning the ethical and legal handling of all records in their school system. The development of additional guidelines relevant to the local situation is encouraged. Finally, it is strongly recommended that state and local counselor associations implement these principles and guidelines through appropriate legislation.

Professional school counselors should be aware that it is much more difficult to guarantee confidentiality in group counseling than in individual counseling. Communications made in good faith may be classified as privileged by the courts, and the communicating parties will be protected by law against legal action seeking damages for libel or slander. Generally, it may be said that an occasion of this particular privilege arises when one acts in the bona fide discharge of a public or private duty. This privilege may be abused or lost by malice, improper and unjustified motive, bad faith or excessive publication.

**Summary:** A counseling relationship requires an atmosphere of trust and confidence between student and counselor. A student has the right to privacy and confidentiality. The responsibility to protect confidentiality extends to the student's parent or guardian and staff in confidential relationships. Professional school counselors must adhere to P.L. 93-380.

## II. Guidelines regarding confidentiality

### B. Professional Association Policy Statements

#### **4. JAMA Editorial**

#### ***Limiting Confidentiality of Adolescent Health Services: What Are the Risks?***

Journal of the American Medical Association, August 14, 2002, Vol 288, No. 6, pp 752-753.

Carol A. Ford, MD. Abigail English, JD

Available online from: <http://jama.ama-assn.org/cgi/reprint/288/6/752.pdf>

IN THIS ISSUE of THE JOURNAL, REDDY AND COLLEAGUES<sup>1</sup> describe the potential consequences of limiting confidential health care on adolescent girls' willingness to use family planning services for prescription contraception and sexually transmitted infections (STIs). Although the study results do not challenge the value of effective communication between parents and children about sensitive issues, including sexuality, they highlight the risks associated with mandating parental involvement in adolescent health care. Moreover, the research findings will help to inform the debate about privacy and minors' access to health care.

A substantial proportion of sexually active adolescent girls who seek health care for prescription contraceptives or services related to STIs are likely to request that their parents not be informed. Defining the physician's role in this situation can be complex. In deciding whether to offer confidential care, physicians must take into account factors such as the patient's chronological age, cognitive and psychosocial development, exposure to abuse or exploitation, other health-related behaviors, and prior family communication. Physicians are also guided by the policies of professional organizations that often support the provision of confidential health care to minors who request privacy for a broad range of health services, including STI treatment, contraceptive care, outpatient mental health services, and outpatient substance abuse services.<sup>2</sup> Confidentiality in adolescent care has been justified from a developmental perspective based on adolescents' need for increasing autonomy as they approach adulthood and their increasing capacity to give informed consent. Confidential care also is justified by a desire to safeguard public health and the health of adolescents who might not seek care for important concerns if their privacy were not protected.

A legal framework developed in the United States throughout the past 3 decades supports the provision of confidential health care to minors in many circumstances.<sup>3</sup> Even the laws that seek to balance confidentiality for adolescents with parental access to information have generally granted discretion to physicians to determine when disclosure to parents is warranted, rather than mandating parental notification outright.<sup>4,5</sup> Recently, however, there have been numerous attempts to limit minors' access to confidential services for sensitive health care issues through proposals to mandate either parental consent or parental notification.<sup>3</sup> Although many of these attempts have focused on minors' access to contraceptive services, they have also included broad attempts to repeal minor consent laws or to expand parents' access to medical information about confidential services.<sup>3</sup> As these initiatives are considered by legislatures, courts, and administrative agencies, defining the risks of limiting adolescents' access to confidential health services is important.

Research has demonstrated that even though confidential health services are theoretically now available to most minors, adolescents report that concerns about privacy limit their health care use. In 2 large nationally representative surveys, approximately one quarter of middle school and high school students reported that



they did not seek health care they needed.<sup>6,7</sup> Klein et al<sup>6</sup> found that 35% of students who did not seek care reported one reason was "not wanting to tell their parents." In regional studies, the proportion of adolescents who report that they would forgo care for contraception, STIs, substance use, or mental health concerns because of fears about parental notification is higher.<sup>8</sup> When adolescents with privacy concerns do seek health care, many may delay obtaining care,<sup>9</sup> preferentially choose sites that offer confidential care (such as family planning clinics),<sup>10,11</sup> and limit their communication with physicians about sensitive health topics.<sup>12</sup> If adolescents' access to confidential care for sensitive health issues were significantly limited or eliminated, privacy concerns would likely have an even greater impact on adolescents' use of health care.

Reddy and colleagues<sup>1</sup> confirm the negative impact that mandated parental notification is likely to have on health care use among adolescents with concerns related to sexual behaviors. More important, their findings provide an indication of the potential magnitude of negative outcomes. Essentially one half of single, sexually active girls younger than 18 years who were surveyed in family planning clinics in Wisconsin reported that they would stop using the clinics under conditions of mandatory parental notification for prescription contraceptives. Subsample analyses showed that these girls would use less effective contraceptive methods or no contraception at all. An additional 12% reported that they would delay or discontinue use of specific services such as health care for STIs. Only 1% indicated that they would stop having sexual intercourse. Although age and race influenced results, the proportions of adolescent girls who reported that they would stop or alter their use of sexual health care services under conditions of mandatory parental notification were remarkably high across all groups.

If the majority of adolescents receiving confidential health services in family planning clinics were to modify their use of or stop seeking services, the impact on rates of teen pregnancy and STIs would undoubtedly be substantial. Prescription methods of contraception are associated with lower rates of pregnancy compared with nonprescription methods.<sup>13</sup> Sexually active adolescent girls are usually screened for chlamydia infection during family planning evaluations for prescription contraceptives, which is an important strategy to reduce rates of this common and often asymptomatic curable STI and prevent pelvic inflammatory disease. Adolescents who have symptoms or are worried that they may have an STI need to be evaluated and treated if infected. These services should be widely available and provided confidentially, if needed, in family planning and traditional health care settings.

Support for confidential services is often perceived as precluding efforts to strengthen parent-teen communication, but that perception is erroneous. There is no reason that efforts to strengthen communication between adolescents and their parents cannot take place even though confidential health care is available to adolescents who need or want it. Although linking parent-adolescent communication with reduced adolescent sexual risk taking is complex,<sup>14</sup> there is widespread consensus that communication between adolescents and their parents about sexual decision making is important. Professional organizations suggest that physicians encourage parental involvement,<sup>2,15,16</sup> which may include reinforcing parents' responsibility to talk with their children about sexuality, exploring with adolescent patients the potential advantages and disadvantages of discussing sexual decision making with their parents, and encouraging or offering to facilitate parent-teen communication.

Acknowledging that not all parents and teens will be able to communicate effectively and that some adolescents will not seek some services without assurance of privacy protection, professional organizations also support the availability of confidential adolescent health services within existing legal frameworks.<sup>2,15,16</sup> Recently, professional health care organizations have supported provisions of the new federal medical privacy regulations that protect minors' privacy when they are legally authorized to consent to their own health care.<sup>17,18</sup> One of the primary rationales for doing so is that such protections are necessary to encourage adolescents to seek care that is essential to protect their health. The risks of limiting adolescents' access to confidential health care through mandatory parental notification, or any other mechanism, are high. The greatest risk is that adolescents who need health care will not receive it and will experience preventable negative outcomes, endangering their own health and often the public health as well. This outcome is not in the best interest of adolescents, their parents, or professionals dedicated to preserving the health and well-being of this age group.



## **REFERENCES**

1. Reddy DM, Fleming R, Swain C. Effect of mandatory Parental notification on adolescent girls' use of sexual health care services. *JAMA*. 2002;288:710-714
2. Gans J. Policy Compendium on Confidential Health Services for Adolescents Chicago, III: American Medical Association; 1993.
3. English A, Morreale M. A legal and policy framework for adolescent health care: past, present, and future. *Houston J Health Law Policy*. 2001;1:63-108.
4. English A, Morreale M, Stinnett A, Boburg E, Hirsch C, Kenney K. State Consent Statutes: A Summary. 2nd ed. Chapel Hill, NC: Center for Adolescent Health & the Law. In press.
5. Standards for Privacy of Individually Identifiable Health Information; Final Rule. 65 Federal Register (codified at 45 CFR §164.502(g)(3)) (2000).
6. Klein J, Wilson K, McNulty M, Kapphahn C, Collins K. Access to medical care for adolescents: results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *J Adolesc Health*. 1999;25:120-130.
7. Ford C, Bearman P, Moody J. Foregone health care among adolescents. *JAMA*. 1999 ; 282:2227-2234.
8. Marks A, Malizio J, Hoch J, Brody R, Fisher M. Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population. *J Pediatr*. 1983; 102:456-460.
9. Zabin L, Stark H, Emerson M. Reasons for delay in contraceptive clinic utilization: adolescent clinic and nonclinic populations compared. *J Adolesc Health*. 1991; 12:225-232.
10. Cheng T, Savageau J, Sattler A, DeWitt T. Confidentiality in health care: a survey of knowledge, perceptions, and attitudes among high school student. *JAMA*. 1993;269:1404-1407.
11. Sugerman S, Halfon N, Pink A, Anerson M, Valle L, Brook R. Family planning clinic clients: their usual health care providers, insurance status, and implications for managed care. *J Adolesc Health*. 2000;27:25-33.
12. Ford C, Millstein 5, Halpern-FeIsher B, Irwin C. Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seep future health care. *JAMA*. 1997;278:1029-1034.
13. Hatcher RA, Trussell J, Stewart F, et al. *Contraceptive Technology*. 17th ed. New York, NY: Ardent Media Inc; 1998.
14. Jaccard J, Dodge T, Dittus P. Parent-adolescent communication about sex and birth control: a conceptual framework.in: Feldman S, Rosenthal D, eds. *Out in the Open: Parent-Teen Communication About Sexuality*. San Francisco, Calif: JosseyBass. In press.
15. Council on Scientific Affairs, American Medical Association. Confidential health services or dolescents. *JAMA*.1993;269:1420-1424.
16. Sigman G, Silber T, English A, Epner J. Confidential health care for adolescents: position paper of the Society for Adolescent Medicine. *J Adolesc Health*. 1997;21:408-415.
17. Standards for Primacy of Individually Identifiable Information; Proposed Rule. 67 Federal Register (codified at 45 CFR §164,502(g)(3)) (2002).
18. Ambulatory Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Medical Association, American Pediatric Society, American Psychiatric Association, American Psychological Association, American Public Health Association, Association of Maternal and Child Health Programs, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, Society for Adolescent Medicine, and the Society for Pediatric Research. Letter to the US Department of Health and Human Services, Office for Civil Rights, regarding Standards for Primacy of Individually Identifiable Health Information; Proposed Rule (April 26, 2002) [on file with Carol A. Ford, MD, and Abigail English, JD].

### III. Guidelines and Models

#### A. *Models for dealing with confidentiality and informed consent*

In this section, we have abstracted information from five different sources that provide models of how to handle Confidentiality and Informed Consent. Each source describes how it approaches these concerns and provide sample forms.

#### **(1) From: *Glass walls: Confidentiality provisions and interagency collaborations***

San Francisco, CA: Youth Law Center. (<http://www.ylc.org>)

Prepared by M. I. Soler, A. C. Shotton & J. R. Bell.

A. The interests of children and families in protecting private information from unauthorized disclosure are significant and should not be disregarded. These interests include:

1. The core interest in privacy (“the right to be let alone”);
2. Avoiding embarrassment and humiliation from disclosure of personal or family problems;
3. Avoiding exposure of information that is inherently inflammatory (such as allegations of child abuse or mental instability), even if the information is unproven or inaccurate;
4. Protecting personal security (such as the location of victims of domestic violence);
5. Protecting family security (such as citizenship status, for immigrant families);
6. Protecting job security, particularly when personal problems may have no connection with actual job performance;
7. Avoiding prejudice or stereotyped responses as a result of information on family income level, medical status, or past difficulties;
8. Preventing denial of discretionary services;
9. Encouraging adolescents to seek medical care; and
10. Reestablishing privacy boundaries for children, especially after abuse or multiple out-of-home placements.

B. Balanced with these interests in privacy are the interests of agencies in sharing information. In many situations, children and families share these interests in the effective and efficient provision of services. The interests of agencies (and families) include:

1. Conducting comprehensive child and family assessments and evaluations for services;
2. Providing children and families with all necessary services;
3. Coordinating service plans and strategies and avoiding duplication of services;
4. Monitoring the provision of services;
5. Making services family-focused;
6. Allowing research on community needs and program effectiveness;
7. Promoting public safety (e.g. by sharing information about potential child care workers regarding prior criminal convictions); and
8. Securing full reimbursement from federal and other funding sources for services provided.

C. Reviews of privacy protections and confidentiality restrictions in federal and state constitutions, statutes, regulations, and agency practices, as well as those in various professional standards indicate that confidentiality restrictions are not significant barriers to interagency collaborations. Further, confidentiality restrictions are not absolute, but instead balance individual interests in privacy against agency interests in providing effective services.

D. Some information, such as that which does not identify specific individuals, is not confidential at all and may be shared freely. Other very basic information, like educational “directory information,” is also not considered confidential.

E. The most common way of information-sharing takes place through informal exchanges, usually verbal and by telephone. This generally occurs between workers in different agencies who have developed a high degree of trust and cooperation. However, if documents need to be shared, a written release or other formal mechanism is required. (see Sample Form A.)

F. Most statutes explicitly authorize a certain degree of information-sharing without consent of the individual for purposes such as:

1. Administration of the program;
2. Audits;
3. Determinations of eligibility for services;
4. Medical emergencies;
5. Investigations, prosecutions, or civil or criminal proceedings related to program administration.

G. Virtually, all statutes authorize information-sharing with the consent of the client. Such information-sharing generally requires a written release specifying the following:

1. Name of the person who is the subject of the information;
2. Name of the person or agency with whom the information will be shared;
3. The reasons for sharing the information;
4. The kind of information that will be shared;
5. The signature of the person giving consent;
6. The date the release is signed;
7. A statement that the release may be revoked at any time by the person giving consent;
8. An expiration date for the release; and
9. A statement that the person giving consent is entitled to a copy of the release. (see Sample Forms B, C, D & E.)

H. Agencies may enter into agreements such as interagency agreements, memoranda of understanding, contracts, court orders, and other mechanisms for sharing information among agencies. (see Sample Forms F & G). A good example of using these mechanisms simultaneously is the Caring Connection program in Iowa (see Sample Form H) and the Fulton County Kids Project in Kentucky. (see Sample Form I.)

I. In using aggregate information systems, particularly automated information systems containing identifiable information, protective mechanisms must be in place to ensure the proper disclosure of confidential information. Using such systems while ensuring client privacy requires the following:

1. Clarifying the purposes of the information system;
2. Limiting the information in the system to that truly needed to fulfill those purposes;
3. Securing the cooperation of multiple agencies in developing and operating the system;
4. Providing adequate notice to children and families that information about them is being put into an information system and will be accessible to others for specific purposes;
5. Maintaining several levels of security in the system;
6. Providing adequate training for staff.

J. It is the responsibility of agency workers to comply with whatever established procedures for information sharing and confidentiality. This may include such methods as staff training and training materials, staff oaths and other restrictions and the roles of agency counsel and other “gatekeepers”.

Sample form A: Example of Limited Authorization to Release Confidential Information

Sample form B: Consent to Exchange Confidential Information

Sample form C: Authorization for Release and Exchange of Information

Sample form D: Authorization to Release Information (English/Spanish)

Sample form E: Consent to Treatment and Consent for Release of Confidential Information

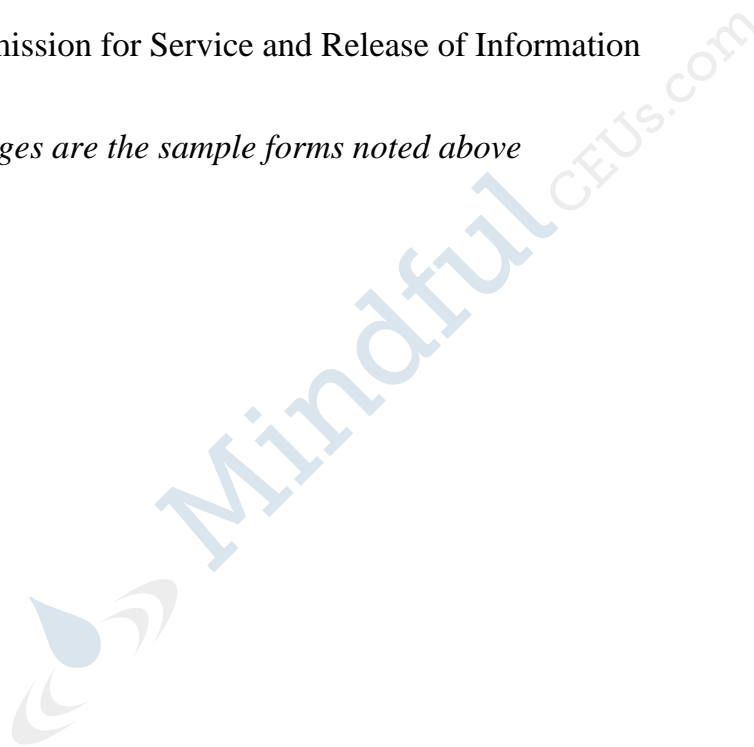
Sample form F: Memorandum of Understanding

Sample form G: Protocol on Consent to Exchange Confidential Information

Sample form H: Authorization to Release Information

Sample form I: Permission for Service and Release of Information

\* *On the following pages are the sample forms noted above*



# Sample Form A

SAN DIEGO

D-R-A-F-T

RELEASE-LIMITED

## EXAMPLE OF LIMITED AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

### CONSENT TO PARTICIPATE AND AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

#### I. **PROGRAM PURPOSE:** (Statement must answers who, what and why)

The Center is a service jointly funded and governed by city, county, private and School Agencies for families and children served by the school. The names of participating agencies and programs are: (Specify the names of the agencies /programs must be stated to assure the participant is properly informed.) All have agreed to cooperate to better serve you and your child(ren) and to protect your confidential records. The purpose of the Center is to provide families the support they need to enable their child(ren) to achieve maximum academic, social and personal growth; and to assist families in obtaining health, education, social and community services as needed.

#### II. **REASON FOR LIMITED RELEASE:** (Statement must give the purpose of the release)

Center staff and staff from the participating agencies (hereafter called Extended Team) who work at or with the Center need to communicate with each other on your behalf. Your initials and signature on this form gives your written consent for Center staff and the Extended Team to verbally share certain information on your family circumstances. This release also gives designated Center staff permission to review and record certain information from the automated files of the participating agencies. The purpose is to: better coordinate Services between the Center and participating agencies who can or are providing services to you, your child(ren). or your family; minimize duplicate efforts by you and the staff working on your behalf to verify certain facts about the family held by a participating agency; and develop the best service plan for and with you.

#### III. **PARTICIPANT AGREEMENT/AUTHORIZATION:** Initial the black line(s) to acknowledge you have read, understand, and agree with the statements.

\_\_\_\_\_. I wish to receive services from the Center for my child(ren) enrolled in the schools myself, and other \_\_\_\_\_ members of my family for whom I am the parent or guardian.

\_\_\_\_\_. I authorize Center case management staff and Extended Team members from the participating agencies to verbally exchange the following personal information only about me and my minor child(ren) from their case files: (Identify the information to be exchanged.)

Example statement: Summary information about the agency(s) service plan for health, education and social services, and the level of achievement of the plan(s) Summary is defined as general statements only and precludes diagnosis and specific treatment information on any services given by a health care provider and any information specifically precluded by law under this simplified procedure.



Sample Form B

County of San Bernardino  
CHILDREN'S INTERAGENCY  
**CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION**  
PLEASE TYPE/PRINT ALL INFORMATION

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Social Security No. \_\_\_\_\_ Record No. \_\_\_\_\_

I authorize San Bernardino County Department of \_\_\_\_\_  
to exchange information with:

\_\_\_\_\_  
Agency/Person/Organization

\_\_\_\_\_  
Address

about information obtained during the course of my/my child's treatment/case/service plan for:

\_\_\_\_\_  
The exchange of records authorized herein is required for the following purpose:

\_\_\_\_\_  
Restriction: Release or transfer of the specified information to any person or agency not named herein is prohibited unless indicated below:

Such exchange shall be limited to the following specific types of information: \_\_\_\_\_

\_\_\_\_\_  
This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and If not earlier revoked, it shall terminate. without express revocation on:

\_\_\_\_\_  
Date, Event, or Condition

I understand I am entitled to receive a copy of this consent. \_\_\_\_\_ copy(ies) requested and received. I have read this consent carefully and have had all my questions answered.

Date \_\_\_\_\_  
Signed \_\_\_\_\_

Parent, Gaurdian Conservator

Witness \_\_\_\_\_  
Signed \_\_\_\_\_

Case Manager/County Representative  
Agency \_\_\_\_\_

**-CONFIDENTIAL CLIENT INFORMATION-**

SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND SECTION 10850. CIVIL CODE 34, 56  
and 1798. 42 C.F.R. SECTION 2.34 AND 2.35. EDUCATION CODE 49075. HEALTH AND SAFETY CODE 1795.

## RELEASED RECORDS

The following records and/or information was released to:

<input type="checkbox"/>	Summary of Record	<input type="checkbox"/>	Psychiatric Evaluation	<input type="checkbox"/>	Results of Psychological/Vocational Testing
<input type="checkbox"/>	Diagnosis/Assessment	<input type="checkbox"/>	Medical Assessments, Lab Tests, etc.	<input type="checkbox"/>	Other (specify)
<input type="checkbox"/>	Social History	<input type="checkbox"/>	History of Drug/Alcohol Abuse		
<input type="checkbox"/>	Treatment Plan		Other Evaluations/Assessments (specify)		
	Financial Information				

Released by:

SIGNATURE \_\_\_\_\_

TITLE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Month Day Year

### AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Citation Examples:  
Health and Safety Code 5  
W&I Code 10850 and 5328  
Ed. Code 49075  
Civil Code 56 and 1796  
42 CFR Part 2

Case Name:

Case Record No.:

Date of Birth:

## Sample Form C

LINN COUNTY, OREGON  
**ALBANY YOUTH SERVICES TEAM**  
**AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

I, \_\_\_\_\_, authorize the release of information between and among the identified Albany Youth  
Parent/Guardian Signature  
Services Team members which will be planning services for \_\_\_\_\_.

Client(s) Name(s) (Please include all family members)

The purpose of the Authorization Form is to enable agencies identified as members of the Albany Youth Services Team to better serve your child through coordinated service planning and delivery. Representatives of these agencies will meet and share information regarding your child a scheduled planning and review meetings.

The Albany Youth Services Team for your child shall include the following agencies:

- \*Greater Albany Public Schools
- \*Children's Services Division, Linn and Benton Counties
- \*Linn and Benton County Alcohol & Drug Treatment Programs
- \*Linn County Dept. of Health Services
- \*Linn-Benton Education Service District
- \*Adult and Family Services
- \*Linn and Benton County Juvenile Department
- \*Albany Police Department
- \*Linn and Benton County Sherrif's Department
- \*Oregon State Police
- \*State of Oregon Parole and Probation
- \*Other \_\_\_\_\_

To assist in determining the availability of resources, please put a check in the box if your child has a:

☐

**Medical Card**

or

☐

**Private Insurance**

The information which may be disclosed/exchanged is: presence in the program, and school, legal and treatment records which include assessment, family history, diagnoses and treatment recommendations from the Linn County Mental Health and Alcohol and Drug Treatment Program.

This release authorizes a free exchange of information between members in order to give the members complete and thorough services available. It does not authorize release to any other person or agency except those agencies listed above. Unless revoked In writing, this release and exchange shall remain in force for a period of 12 months from the date of authorization.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CDR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the pars to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient for this purpose.

\_\_\_\_\_  
**Witness**

**Date**

\_\_\_\_\_  
**Authorizing Signature**

**Relationship to Child**

\_\_\_\_\_  
**Juvenile's Signature (12 and over)**

Sample Form D  
(English Version)

LONGFELLOW ELEMENTARY SCHOOL  
3610 Eucalyptus Avenue  
Riverside, California 92507  
Interagency Project SMART Program  
Authorization to Release Information

We have many services here at Longfellow to help you and your family. To receive this help and to make sure that you get all the help you and your family needs we may need to share information. I, \_\_\_\_\_  
\_\_\_\_\_ hereby authorize release of all records, documents and information on my son, my daughter, and/or  
my family which is or may come on file with the agencies here at Longfellow Elementary School/Project  
SMART.

The following agencies may or will provide the services:

- The Youth Service Center
- Mental Health Counselor
- Public Health Nurses
- Public Health Van
- Social Worker
- Psychologist
- State Evaluator
- GAIN Worker
- AFDC Eligibility Technician
- MediCal Technician
- Day Care
- The Family Advocate
- School personnel

I understand that the following information may be released to the above stated providers:

1. The full name and other identifying information regarding my child and our family.
2. Recommendations to other providers for further assistance.
3. Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, educational and social histories. These evaluations may include some or all family members.

The purpose of this disclosure shall be to facilitate service delivery to my child(ren) and my family. I further understand that the information generated or obtained by the project can be shared with the agencies or providers that are a part of this project.

I also understand that this Authorization for Release of Information will be in effect for the duration of services provided to my child(ren) and my family and will expire upon the termination of the services. I understand I can revoke this consent at any time and this consent shall be reviewed annually.

I certify that I have read and understood the consent of this form. \_\_\_\_ **Yes, I agree to sign.** \_\_\_\_ **No, I do not agree to consent.** **Please list all children attending Longfellow School.**

\_\_\_\_\_  
Parent or Guardian Name (Please Print)

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Room #

\_\_\_\_\_  
Authorized Project SMART Staff

\_\_\_\_\_  
Students Name

\_\_\_\_\_  
Room #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Room #

Sample Form D  
(Spanish Version)

LONGFELLOW ELEMENTARY SCHOOL  
3610 EUCALYPTUS AVENUE  
RIVERSIDE, CALIFORNIA 92507  
Programa del Proyecto SMART do Interagencias  
Autorizacion Para dar Informacion

Tenemos muchos servicios aqui en la escuela Longfellow para ayudarle a usted y a su familia. Para recibir esta ayuda y para aseguramos de que reciba usted y su familia la ayuda necesaria, tal vez sea necesario compartir informacion. Yo \_\_\_\_\_, doy autorizacion de compartir-toda informacion del expediente, documentos, a informacion sobre mi hijo, mi hija, y/o mi familia que pueden estar en el archivo en las agencias aqui en la Escuela Longfellow y el Proyecto SMART.

Las siguientes agencias pueden o seran las agencias que daran los servicios:

- Centro do Servicio Juvenil
- La consejera de salud mental
- Las enfermeras do salud publica
- Camion de Salubridad
- La trabajadora social
- El Psicologo
- El evaluador del estado
- Trabajador de Gain
- Trabajadores do Elegibilidad de AFDC
- Trabaiaador de MediCal
- Cuidado de ninos
- La Ayudante do Familias
- Personal do la escuela

Yo entiendo que la siguiente informacion puede ser compartida can las personas mencionadas arriba:

1. El nombre completo y otra informacion de identificacion sobre el nino o la familia.
2. Recomendaciones a otras agencias para recibir mas ayuda.
3. Informacion sobre exámenes de Diagnostico y evaluacion del psicologo a psiquiatra, historia medica, y antecedente educativo y social. Esta informacion puede ser sobre toda o parte de la familia.

La razon par la cual se necesita toda esta informacion es para facilitar servicio a todos mis ninos o la familia. Yo entiendo que esta informacion sera unicamente usada para este proyecto y solo sera dada a las agencias que son parte de este proyecto.

Yo entiendo que esta Autorizacion de Informacion sera vigente durante el servicio dado a mis hijos y familia y expira al terminar los servicios. Yo entiendo que yo puedo revocar este consentimiento en cualquier momento y que yo revisare este consentimiento cada ano.

Yo certifico quo yo he leído y entiendo este documento. \_\_\_\_\_ **Si, Yo estoy do acuerdo firmar.** \_\_\_\_\_  
**No, Yo no estoy de acuerdo firmar.** Por favor ponga todos los nombres de sus ninos que asisten a la escuela Longfellow.

\_\_\_\_\_  
Nombre del Padre o Tutor(Letra do molde)

\_\_\_\_\_  
Firma del Padre o Tutor

\_\_\_\_\_  
Nombre del estudiante(s)

Salon  
Salon

\_\_\_\_\_  
Firma de Persona de Proyecto SMART

\_\_\_\_\_  
Fecha

## Sample Form E

**CONSENT TO TREATMENT  
AND  
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION:  
BLUEGRASS INTERAGENCY MOBILIZATION FOR PROGRESS IN ADOLESCENT AND  
CHILDREN'S TREATMENT  
INTERAGENCY INFORMATION EXCHANGE**

I, \_\_\_\_\_, hereby declare that I am the parent \_\_\_\_ or guardian \_\_\_\_ who is a child (SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ) applying for services provided by Bluegrass IMPACT, a project of the Cabinet for Human Resources and the Bluegrass Regional Mental Health/Mental Retardation Board. Inc. I hereby give permission to those agencies or providers affiliated with Bluegrass IMPACT, a listing of which has been given to me, to provide services to my child including consultation with agencies which way not have had direct contact with my child.

I recognize that the services for my child's condition require the collaboration of numerous agencies and service providers. I understand that this collaboration requires the disclosure of information about my child so as to help the various service providers to make necessary assessments and service plans.

I understand that the following information may be released to service providers:

- 1.The full name and other identifying information regarding my child and our family.
- 2.Diagnostic and assessment information including psychological and psychiatric evaluations, medical histories, educational and social histories. These evaluations may include references to other family members.
- 3.Treatment and/or educational rehabilitation or habilitation plans.
- 4.Current observations a f behavior.
- 5.Recommendations to other providers.

The purpose of this disclosure shall be to facilitate service delivery to my child.

I further understand that the information generated or obtained by the project can be shared with the agencies or providers affiliated with the project.

This authorization to release information extends to the various interagency committees and response teams of project IMPACT. I authorize data to be shared with the Cabinet for Human Resources. Department for Mental Health and Mental Retardation Services, Division of Mental Health. The purpose of this disclosure is to assist in needs assessment and planning for future services.



## Sample Form F

### MEMORANDUM OF UNDERSTANDING BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH AND THE NEW YORK STATE DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE

WHEREAS, the Division of Alcoholism and Alcohol Abuse (DAAA) has a statutory responsibility to establish and operate alcoholism treatment and rehabilitation services; and

WHEREAS, both the Department of Health (DOH) and DAAA have promulgated HIV confidentiality regulations pursuant to Article 27-F of the Public Health Law allowing for the disclosure of information to state agencies when necessary for the supervision, monitoring or administration of a program; and

WHEREAS, DAAA funds Alcoholism/HIV Coordinators through Community Service Programs (CSPs) whose activities must be monitored and evaluated by DAAA through data collection, and DOH funds CSPs whose activities must be monitored and evaluated through data collection; and

WHEREAS, DOH has developed and implemented an existing information system to monitor and evaluate the CSP as a whole; and

WHEREAS, both DOH and DAAA are committed to reducing duplication of effort in data collection and reporting by the CSP;

NOW, therefore, DOH and DAAA do hereby agree as follows:

1. DOH and DAAA will jointly adhere to established procedure for the collection and sharing of data necessary to monitor Alcoholism/HIV coordinator activities.
2. DOH will add codes specific to alcoholism services to the forms used by CSPs for reporting client services rendered and will note that *information will* be utilized by DOH and DAAA. Such codes will not contain client identifying information.
3. In order to comply with federal and state confidentiality laws, DAAA and DOH will strictly maintain the confidentiality and security of shared data through the following procedures:
  - a. Data transactions between DAAA and DOH will occur primarily via computer disk. Use of this and other media for transmission shall adhere to specified regulations and other procedures set forth in this agreement.
  - b. DAAA will submit to DOH a list of non-identifying alcoholism client numbers for individuals for whom data is required. Such requests will be limited to one per calendar quarter.
  - c. DOH will return alcoholism client number list with the requested data.
  - d. DAAA will restrict access to client data from CSP providers and Alcoholism/HIV Coordinators permitting access only to DAAA staff who have been authorized by DAAA to enter, edit and analyze said data.
  - e. DAAA shall develop and will adopt guidelines concerning the reporting of statistical data to be implemented in instances where low frequencies in tabular cells may jeopardize confidentiality.
4. DAAA agrees to submit budget requests including funds to support initiatives contained in the AIDS Five Year Plan for which DAAA has implementation responsibility during the corresponding fiscal year, unless funding from an alternate source is known to be available to support such implementation.
5. This agreement will commence April 1, 1990 and remain in effect until termination by either party. To terminate, a party must give to the other party not less than sixty (60) days written notice that on and after a date therein specified, this agreement shall be terminated and cancelled.

Division of Alcoholism Department of Health  
and Alcohol Abuse

Department of Health

BY: \_\_\_\_\_

BY: \_\_\_\_\_

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

## Sample Form G

### SAN BERNARDINO COUNTY CHILDREN'S INTERAGENCY

#### **Protocol On Consent To Exchange Confidential Information**

Member agencies enter into this protocol to utilize one standard Release of Information form for authorization to release confidential information and records about children and families served by one or more member agencies. This form is intended to allow the case worker to use one form to access and send records to and from other mental health, drug and alcohol, education, probation and social services providers. The goal is to have a form which, when properly completed, allows the receiving organization to copy or file it and act upon it without further releases.

Use of a standard release form by all member agencies is intended to better coordinate services between participating agencies who can or are providing services to the same families: minimize duplicate efforts to verify certain facts needed for rendering services; and to help develop the best level of integrated, effective services.

All member agencies agree to develop written guidelines for their staff in using and accepting this form and to train their staff prior to the agreed upon date of implementation. All staff will be informed that the form must be completed in its entirety. The release shall be specific about the nature of information requested. The form shall be time limited with a specific ending date. The release must be signed and dated with a copy given to the signatory. The signatory must be fully informed of the purpose for the release. Staff shall be trained on specific exceptions in exchange of confidential information such as:

- Information given pursuant to mandatory reporting laws,
- Information from an informant, particularly a minor,
- Sensitive health information, such as HIV test results,
- Third party confidential reports, particularly medical reports.

Use of this form in to assist families to participate in the decision to exchange information in order to receive better services. The overall intent however, is to provide families and children their full protection for confidentiality under the law and to ensure families understand and exercise their rights to privacy accordingly

Nothing in this protocol limits existing practices for exchanging confidential information at the Regional Case Management Councils established under the Children's Services Team as Multi-Disciplinary Teams authorized to exchange information under a standing court order from the presiding juvenile court judge pursuant to WIC Section 827 and 828.

## Sample Form H

### CARING CONNECTION AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Student: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**The Caring Connection is a program designed to provide a comprehensive set of services to youth in an effort to assist teenagers in completing high school, becoming employable and remaining mentally and physically healthy. The services available under this program are related to employment, preventative and primary health care, mental health, substance abuse and family counseling.**

#### AUTHORIZATION

\_\_\_\_\_ desires to participate in this program and authorizes the Mental Health Center of Mid-Iowa, Inc., Substance Abuse Treatment Unit of Central Iowa, Job Training and Partnership personnel, Marshall County Youth Runaway & Family Services, MidIowa Community Action, Y.M.C.A. Outreach Program, his or her school guidance counselor, school nurse, employees of the Caring Connection and

\_\_\_\_\_, to exchange among themselves for coordination of services the following  
(specify any other health care providers)

records relating to the student's care and treatment:

- \_\_\_\_ summaries and notes of participation in treatment
- \_\_\_\_ evaluations and recommendations
- \_\_\_\_ psychological and psychiatric testing and evaluation results
- \_\_\_\_ discharge reports
- \_\_\_\_ academic records
- \_\_\_\_ information relating to medical history
- \_\_\_\_ information relating to social history
- \_\_\_\_ information relating to alcohol and other drug use
- \_\_\_\_ information an legal history
- \_\_\_\_ other information

\_\_\_\_\_ understands he/she has a right to inspect the disclosed information and information being exchanged at any time, and hereby states that this authorization shall be effective for \_\_\_\_ months from the date it is signed. \_\_\_\_\_ also understands that he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Caring Connection or the individual health care providers.

A photocopy or exact reproduction of this authorization shall have the same force and effect as the original. I hereby authorize release of information as indicated above and acknowledge that I have received a copy of this document.

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Legal Representative**

\_\_\_\_\_  
**Date**

#### SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State Law applicable to substance abuse and mental health. I SPECIFICALLY AUTHORIZE release of all confidential information as set forth herein Mating to substance abuse (drug or alcohol information) from me Substance Abuse Treatment Unit of Central Iowa and Mental Health Center of Mid-Iowa, Inc., and specifically authorize the disclosure of this confidential information.

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Legal Representative**

\_\_\_\_\_  
**Date**

## Sample Form I

**FULTON COUNTY, KENTUCKY  
FULTON COUNTY KIDS PROJECT  
(KENTUCKY INTEGRATED DELIVERY SYSTEM)**

**Student Identification:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.# : \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address (if different from student): \_\_\_\_\_

**Permission for Service:**

Permission is hereby given to the staff of the agencies participating in the Fulton County KIDS Project, as listed below, to render services to: \_\_\_\_\_  
whose relationship to me is: \_\_\_\_\_ Child \_\_\_\_\_ Other: \_\_\_\_\_

**Release of Information:**

I, as parent/guardian of the above named child, hereby consent to the release of information by the participating agencies within the Fulton County KIDS Project for oral presentation only at case conference meetings. This information will not be released to other non-participating agencies/persons without the express written consent of the parent/guardian and prior written notification of the school district. I understand and have had explained to me that the sharing of information will enable the participating agencies to provide my child/family with the most efficient and effective services. This release may be withdrawn upon receipt by the school district of the written notification of revocation.

This consent form is valid for a period of time beginning \_\_\_\_\_  
and ending \_\_\_\_\_.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

I understand that the following agencies will be participating as needed in the case conference and will be exchanging oral information concerning my child/family:

Department of Vocational Rehabilitation  
Department for Social Services  
Department for Social Insurance  
Purchase District Health Department  
Commission for Handicapped Children  
Department for Employment Services  
Administrative Office of the Court-Juvenile Services Division  
Western Kentucky Regional Mental Health-Mental Retardation Board. Inc.  
Fulton County School District  
Fulton Independent school District

### III. Guidelines and Models (cont.)

#### A. Models for dealing with confidentiality and informed consent (cont.)

#### **(2) From: *The need to know: Juvenile record sharing***

by J. A. Rapp, R. D. Stephens, & D. Clontz. National School Safety Center.

A. The following records are confidential and shall not be released to the public except as permitted by this statute.

1. Juvenile court records, which include both legal and social records;
2. Juvenile social service agency, child protective service agency, or multidisciplinary team records whether contained in court files or in agency files, which includes all records made by any public or private agency or institution that has or has had the child under its care, custody or supervision;
3. Juvenile probation agency records whether contained in court files or in probation agency files.
4. Juvenile parole agency records whether contained in court files or in parole agency files;
5. Juvenile prosecutor, state's attorney, district attorney or county attorney records relating to juvenile cases;
6. Juvenile law enforcement agency records, including fingerprints and photographs; and
7. School records maintained by school employees on all students, including, but not limited to, academic, attendance, behavior and discipline records.

B. Access to the records listed in Section A is permitted without court order for official use to the following:

1. All courts;
2. All probation or parole agencies;
3. All attorneys general, prosecutors, state's attorneys, district attorneys and county attorneys;
4. All social service or protective service agencies or multidisciplinary teams;
5. All law enforcement agencies;
6. All schools attended by the minor; and
7. All persons, agencies or institutions that have responsibility for the custody, care, control or treatment of the minor.

C. The juvenile court may issue an order releasing juvenile records to any person, agency or institution asserting a legitimate interest in the case or in the proceedings of the juvenile system.

D. Juvenile records may be sent to a central repository, which may be computerized. The central repository may be accessed by all agencies and organizations listed in section B above.

E. The juvenile, the juvenile's parents or guardian, and the juvenile's attorney may have access to the legal records maintained on the juvenile in possession or the juvenile court without court order. The juvenile's attorney may have access to the social records maintained on the juvenile in possession of the juvenile court and to the records listed in Section A of this statute for use in representation of the juvenile. The juvenile about whom records are maintained may petition the court to correct any information that is incorrect.

#### *Note: Other Disclosures of Juvenile Records*

Several states in recent years have modified their juvenile records statutes to allow public disclosure of records involving serious crimes. Typically, such statutes allow the public to have access to records regarding felony crimes committed by minors who have reached age 15 or 16. Many states also allow victims to obtain information about juvenile records in order to pursue civil remedies.

Such clauses are extremely important and should strongly be considered by those re-drafting their state juvenile records statutes. However, those clauses were purposely left out of this Model Statute because the model focuses only on child-serving agencies sharing records with each other in order to make better professional decisions about children -- not on the wider issue of records access by the general public.

III. Guidelines and Models (cont.)

A. Models for dealing with confidentiality and informed consent (cont.)

**(3) From: Confidentiality and collaboration:  
Information sharing in interagency efforts**

**Prepared by Joining Forces, American Public Welfare Association, Center for Law and Social Policy, Council of Chief State School Officers and Education Commission of the States**

Here is a sample of one of several forms provided in this work.

*Sample Form*  
**Authorization to Release Information**

COUNTY OF CONTRA COSTA  
INTERAGENCY FAMILY PRESERVATION PROGRAM  
Authorization to Release Information

I, \_\_\_\_\_, hereby authorize release of all records, documents, and information on my son, daughter, and myself and/or my family which is or may come on file with Contra Costa County Mental Health Department, Social Service Department, Probation Department, local school agency and Families First to and between these agencies for their utilization when meeting and planning services through their Interagency Referral Committee. I may revoke this consent at any time by notifying the Interagency Referral Committee in writing of my desire to withdraw the consent given herein.

\_\_\_\_\_  
Signature of Consenter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency and Title of Witness



#### **(4) From: *First steps: A guide to integrating information for systems evaluation of children's mental health services***

by D. Hallfors, P. McQuide, C. Brach, & S. Hutcheson. Boston, MA: Judge Baker Children's Center, The Technical Assistance Center for the Evaluation of Children's Mental Health Systems.

Any discussion of sharing information across agencies and with the public, particularly in a computerized format, raises issues of confidentiality, access to information, and privacy rights. Children and families who are being served by public agencies are required to reveal a great deal of intimate and private information about themselves. Much of this information is essential for agencies to make decisions about eligibility and to determine appropriate services, while some of it may be relevant to the overall family situation but not essential to the agency's specific mission. Especially as agencies begin deliberations about sharing information across agencies, they must be alert to the potentially serious consequences of failing to protect the privacy of children and families.

Children and families have a clear interest in privacy protection. This interest might stem from their need to avoid stigmatization from disclosure of personal or family issues; to protect personal security (such as the location of victims of domestic violence); to protect family security (such as citizenship status, for immigrant families); to protect job security; to avoid prejudice or stereotyped responses as a result of information on family income level, medical status, or past difficulties; to prevent denial of discretionary services; and to reestablish privacy boundaries for children, especially after abuse or multiple out-of-home placements.

The interests of children and families in personal privacy are of undeniable importance. When children and families need public services, however, the individual's right to privacy is met by the agency's need to share information for effective and efficient provision of services. Counterbalancing children and families' need for confidentiality are agencies' need to:

- conduct comprehensive child and family assessments and evaluations for services;
- provide children and families with all necessary services; coordinate service plans and strategies, and avoid duplication of services; monitor the provision of services;
- ensure services are family-focused;
- allow research on community needs and program effectiveness;
- promote public safety (e.g., by sharing information about potential child care workers regarding prior criminal convictions); and secure full reimbursement from federal and other funding sources for services provided.

With the coming of automated information systems, agencies are encouraged to collect more information, because the computer gives them the capacity to manage large data sets more easily. However, especially when agencies are considering ways of sharing information they will find that having more information is not necessarily better. Collecting unnecessary information may:

- increase the danger of inappropriate disclosure of information,
- increase costs for collecting and managing information,
- make information sharing more cumbersome, and
- increase the probability that erroneous or misleading information will be disseminated.

Solutions to privacy concerns cannot be legislated or mandated. Open exchange of ideas and the building of trusting relationships will be a first step to addressing privacy concerns. All the relevant parties including family representatives need to be involved in the planning and decision making. They need to see themselves as working toward a common goal which is well served by having agencies share information.

Many administrators regard confidentiality statutes and related regulatory provisions as major impediments to interagency efforts. The 1991 study by the Youth Law Center of San Francisco, which assessed confidentiality issues in interagency collaboration, provides a comprehensive discussion of issues to consider, along with useful mechanisms for sharing information (Soler, Shotton, and Bell 1993). An analysis of legal and ethical issues related to confidentiality reveals that virtually all information-sharing problems can be resolved. Most of the administrators interviewed in the Youth Law Center study indicated that they believed that confidentiality issues are frequently exaggerated and often cover up underlying interagency conflicts over ownership of the data and budget control. However, certain safeguards are necessary in developing computerized information systems, primarily when the systems contain identifiable information on individuals.

Listed below are strategies that agencies can use to overcome conflicts on confidentiality issues after consensus has been built in the planning/decision making process.

**Notify children and families of data sharing arrangements and use mechanisms such as written releases signed by families to authorize the sharing of sensitive data.** Families should be notified that certain information is being put into an automated data system and that it will be accessible to others for specific purposes. The notice should specify the type of information put into the system, the particular individuals or agencies who will have access to it, the reasons for which they may have access to the information, and how they will use it. If the information-sharing requires the consent of the client, agencies should consider the following advice on developing a release form from the Task Force on Enhancing the Mental Health Statistics Improvement Project (MHSIP) to Meet the Needs of Children:

- Avoid broad or blanket releases.
- Print releases in multiple languages.
- Clearly identify the collaborating agencies.
- Specify who is covered by the release and the type and scope of information to be released.
- Explain how the information will be used, by whom, and for what purpose and the benefits and risks associated with releasing, as well as the potential benefits and risks associated with not releasing the information.
- Include the termination date of the release, which includes the mechanism to terminate the release before the date.

**Clarify the purposes of the system.** It is important to keep the purposes of the automated system clear to provide a solid basis for determining what data elements must be included in order to attain the desired goals. Losing sight of the goals can easily lead to the inclusion of data that might be useful someday but does not have any immediate application.

**Employ the Principle of Limited Information.** Limit information going into the system to that which is truly needed to fulfill its purposes. For example, if the database will include the information that a person received medical treatment, it may be sufficient just to indicate when and where, and not to include the details of the client's medical condition and the specifics of the treatment.

**Use non-identifiable information when identifiable information is not needed to accomplish goals.** Aggregate data or individual data that masks the identity of individuals whose information is in the system may be used for many of the planning and evaluation functions of integrated information systems. A number of masking identifiers may be used, including identifying numbers assigned by agencies. Some systems have specialized methods of developing identifiers, such as using certain letters from the last name. The uniqueness of the identifier is critical to maintaining confidentiality. In a cross-agency information system, if identifiers are not unique (e.g., a last name of “Jones”), an agency worker may need to browse through records of a number of persons named Jones to find a particular client. If the worker is relying on a written release from the client to obtain the information, such a lack of precision will result in breaches of confidentiality as the worker views confidential information on other individuals while looking for a specific client.

**Establish appropriate security.** Automated data systems need several levels of security, beginning with security of the physical environment. Physical access to confidential information on disks, tapes, and at workstations should be controlled.

The second level of security is limiting access to the data once they are in the computer system. This can be done with a series of passwords, with each successive password allowing the user to get deeper into the system. A more flexible alternative is to have the system administrator create security profiles which define the package of screens each user can view and limit the functions the user can perform. The security profile would be constructed to give each user (agency worker, researcher, etc.) access only to the information that the user has a legitimate need to know or use. The security profile would use a single password to gain entry, and the system could be programmed to automatically time out people who cannot get their passwords correct after several attempts.

As an additional level of security, agency staff should sign security agreements that prohibit unauthorized disclosure of information.

**Train staff on confidentiality procedures.** Many child welfare agencies, alcohol and drug treatment programs, and programs for people with HIV/AIDS conduct extensive training for staffs on confidentiality procedures to ensure sensitivity to information about child abuse, alcohol and drug abuse, and HIV/AIDS status. Since some models for integrating information systems potentially make more confidential information more available, the need for regular and comprehensive training is that much greater.

**Training should include:**

1. the reasons for protecting the confidentiality of information about children and families;
2. the specific information the agency requires, and the reasons the agency needs the information;
3. information the worker's agency will share with other agencies, and the purposes of that information sharing;
4. the applicable legal provisions, particularly federal and state statutes and regulations;
5. the importance of fully explaining the significance of consent to clients (and staff sensitivity to family language and cultural issues), the requirements of informed consent, and the necessary elements of written releases;
6. interagency agreements, court orders, and other mechanisms that may be used by the agency to facilitate interagency information-sharing without the specific consent of clients;
7. particular considerations that arise in the context of any automated information system utilized by the agency; and
8. participation of family members in development and delivery of training.

**(5) From: *Who should know what?***  
***Confidentiality and information sharing in service integration***  
**by M.I. Solers, & C.M. Peters. New York, NY: National Center for Service Integration.**

The following is a checklist of points that agencies should consider and address in developing procedures for sharing information within and across agencies:

1. Consider the reasons for ensuring the confidentiality of information and children and families.

The fundamental right “to be let alone” is at the root of confidentiality protections.

Confidentiality restrictions protect the privacy of individuals and insure that personal information is disclosed only when necessary. The reasons for respecting the privacy of children and families include the following:

- a. Confidentiality restrictions protect embarrassing personal information from disclosure. This may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.
- b. Confidentiality provisions prevent improper dissemination of information about children and families that might increase the likelihood of discrimination or harm against them even if records show that the information is unproven or inaccurate. Such information includes HIV status, mental health history, use of illegal drugs or child abuse charges.
- c. Protecting confidential information can be necessary to protect personal security. For instance, an abused woman in a domestic violence situation may be in great danger if law enforcers reveal her new location.
- d. Confidentiality provisions also protect family security. For example, many immigrant families shy away from using public health clinics or other social services for that the Immigration and Naturalization Service (INS) will take action against them.
- e. Restricting information disclosure may also protect job security. Information such as history of mental health treatment may bear no relation to job performance but could jeopardize the individual’s position or ability to find employment.
- f. Children and families want to avoid prejudice or differential treatment by people such as teachers, school administrators, and service providers.
- g. Confidentiality provisions also may be necessary to encourage individuals to make use of services designed to help them. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents or peers.

2. Decide on the specific information the agency needs.

In all agency functions, the information collected and recorded should be limited to the data genuinely needed to fulfill agency goals. If, for instance, the agency has a valid need for more information about the client’s medical history, the agency must obtain a specific release for the medical information from the client.

3. Clarify the reasons why the agency needs the information.

Public agencies in human services and education may require children and families to share some of the most intimate and private information about themselves. They need to investigate clients to determine eligibility and appropriate assistance. But agencies should always keep in mind that the goal of obtaining information is to help provide more effective services and will not violate the rights to privacy of children and families.

4. List the information that the worker’s agency will share with other agencies.

Confidentiality statutes and agency practices increasingly emphasize that workers collect, maintain, and share only the information directly relevant to the agency’s purpose. More information is not necessarily better.

5. Describe the purposes of information sharing among agencies.

While it is important to respect the need for privacy and the “right to be let alone,” this right must be balanced with the needs of agencies to know about the children and families they serve in order to provide services effectively and efficiently. Oftentimes, several different systems work with the same children and families simultaneously, and both agencies and the families may benefit significantly from greater cross-system information sharing and collaboration. Reasons include the following:

- a. It may be necessary to have access to information from several agencies to conduct comprehensive assessments of children and family needs.
- b. Agencies also need to share information to provide all necessary services to clients.
- c. Sharing information helps to coordinate service plans and avoid duplication of services. Sharing information avoids wasteful duplication, resolves conflicting demands on clients, and free resources so that agencies can provide more comprehensive care for clients.
- d. Continued sharing of information will facilitate the monitoring of services by each agency. This monitoring ensures that needed services are actually provided and that agencies receive proper reimbursement for mandated services.
- e. Information sharing helps to make services more family-focused. Sharing of information among agencies allows service providers to gain a broader perspective of service needs and provide the family with more appropriate services.
- f. Information sharing also helps agencies reach out to serve the needs of the broader community. It can help determine the effectiveness of programs in place, current community needs that are unmet, projections of the need for services in the future, and the best ways to allocate limited resources.
- g. Information sharing may also promote public safety. For instance, it helps ensure that individuals applying for licenses to operate child residential facilities have not been subjects of confirmed child abuse reports.

6. Study the applicable legal provisions, particularly federal and state statutes and regulations.

Confidentiality regulations come from a variety of sources: the U.S. Constitution, state constitutions, federal and state statutes, agency regulations, professional practice standards, and ethical standards. They may seem excessively vague or unnecessarily complicated and may dissuade professionals from sorting through them to find appropriate ways to share important information. The significant point, however is that confidentiality provisions are not absolute. All contain exceptions to their coverage or specify methods for disclosure. To fully understand a confidentiality provision, one can ask a series of questions:

- a. What information is deemed confidential?
- b. What information is not considered confidential?
- c. What exceptions are there to the confidentiality restriction? What information sharing is authorized? Under what conditions?
- d. Can information be shared with the consent of the client? What information can be released with consent? What are the requirements for a consent release? Who can give consent for information pertaining to minors?
- e. Does the provision authorize other mechanisms for information sharing, such as interagency agreements or memoranda of understanding?

7. Make provisions for clearly explaining the importance of consent to clients.

Notices to clients of an agency’s need to release information are critical to the process of obtaining informed consent. These notices inform clients about the purpose and the extent of the consent being requested. Inadequate and confusing notices may mislead clients and impair the relationship between clients and service providers. Clearly presented notices can inform clients of their rights and help promote trust in the agency. Generally, the client should possess sufficient knowledge of the risks and benefits of the release of information, and should be capable of making a reasoned choice between alternatives. The person should understand what information will be disclosed, to whom it will be disclosed, the purpose of the disclosure, and the benefits of such disclosure.



8. Pay attention to the need for sensitivity to language and cultural issues.

Language and culture may compound the difficulties in obtaining informed consent. A written release of confidential information in a language not understood by the client is invalid. Some confidentiality statutes require that a notice of the consent, or the release form itself be presented in the individual's native language. Agency personnel should also be aware of different cultural customs and attitudes about privacy. Many immigrants fear that the personal information they provide may put them or their families at risk. When this issue arises, release forms should state clearly that no personal information will be given to the Immigration and Naturalization Service.

9. Develop agency or multiagency requirements for informed consent and necessary elements for written releases.

Informed consent is the most common formal mechanism for exchanging information. The individual, who is the subject of the information, gives consent generally through a signed written release. When the person is legally incompetent, because of age for instance, the parent or guardian may sign. Any release of personal information should be in writing. It should contain the following:

- a. The name of the person who is the subject of the information.
- b. The name of the person, program, or agency sharing the information.
- c. The name of the person, program, or agency with whom the information will be shared.
- d. The reasons for sharing the information.
- e. The kind of information that will be shared.
- f. The signature of the person who is the subject of the information.
- g. The date the release is signed.
- h. A statement that the release can be revoked any time by the subject of the information.
- i. An expiration date for the release or a specific event (such as the end of the school year) that will terminate the release.
- j. A notice stating that the subject of the information has a right to receive a copy of the release.

It is good practice to obtain written releases from clients during initial interviews or as services begin. These releases should cover routine information. Further, agencies can develop multiagency or comprehensive release forms that satisfy the confidentiality mandates of the participating agencies. By signing one release form, the client permits the participating agencies to exchange information and to coordinate services for the client.

10. Specify the role of interagency agreements, court orders, and other mechanisms that facilitate interagency information sharing without the consent of clients.

Most federal statutes permit disclosure of confidential information for a variety of administrative purposes without consent of the individual. An agency may share information for a number of reasons, including the following:

- a. Administration of the program or related programs.
- b. Audits.
- c. Determinations of eligibility for services.
- d. Medical emergencies.
- e. Investigations, prosecutions, or civil or criminal proceedings related to program administration.

Authorized sharing of confidential information is common in state statutes. The statutes fall into several categories: broad authorizations for information sharing among agencies, specific authorizations regarding particular types of information (such as child abuse information), and authorizations to share information to develop more comprehensive services for children and families (such as statutes that establish multidisciplinary teams to develop treatment plans).



There are several ways to allow interagency information sharing without the consent of clients. They include:

a. Interagency agreements and memoranda of understanding.

Under several federal and state statutes, agencies may enter into agreements to share information about clients to better achieve service goals. Interagency agreements should specify the following:

- a.1) What information will be shared.
- a.2) How the information will be shared.
- a.3) Who will have access to the information.
- a.4) The purposes for information sharing.
- a.5) Assurances by the participating agencies that they will not disclose the information further except as dictated by the agreement, and that they will resist other efforts to obtain the information.
- a.6) Other requirements mandated by applicable confidentiality provisions.

b. Court orders

These orders issued by courts allow the disclosure of juvenile court information to designated county departments to assist case planning and treatment.

c. Informal exchanges of information

The most common way of information sharing among agencies is informal, usually done verbally and by telephone. These informal exchanges frequently take place without consent or statutory authorization. However, they occur principally when people who need limited bits of information are familiar with each other and have developed a relationship of trust. If an agency participates in this form of information exchange, it should advise clients that such limited, informal information sharing may occasionally be necessary, and then determine whether the clients have objections to the practice.

The agency will be on safest legal grounds if it obtains voluntary consent, in written form, to the exchange of verbal information, and establishes clearly the types of information exchanges that will occur.

## 11. Review the special issues that arise from the use of automated management information systems.

When one agency's records become linked on a computer network with another agency's records for the information sharing, safeguards must be in place to assure that confidential information will not be disclosed improperly. In developing a computerized data system and using it effectively, agencies should go through the following steps:

- a. Determine the purpose of the system. Automated data management may have several purposes. Some purposes focus on the systems providing services such as researching needs for services in the community, reporting services provided by particular agencies, evaluating the effectiveness of services, assessing cost-effectiveness of services, and planning for the future. Other purposes focus on meeting the needs of individual clients which include assisting in comprehensive assessments of client needs, finding services in the community that can meet the client's needs, and tracking the cost of providing the services. Planners should determine the purposes of the system at the design stage because that decision will affect other aspects of the system - such as information accessibility, levels of security, and system usefulness to administrators, policymakers and workers.
- b. Obtain the cooperation of all participating agencies. Agencies must agree on what kind of hardware and software they will use and how they will ensure compatibility. Agencies must also agree on how to identify people in the system, what information each agency will enter into the system, who will have access to the information in the system, how the Information may be used by participating agencies, and which security measures will be

instituted to protect confidentiality and the integrity of the system.

c. Develop thorough security procedures.

Agencies should develop several levels of security to properly safeguard automated data systems:

c.1) Security of the physical environment. Data tapes and disks should remain in locked rooms when not in use. Access to these materials should be strictly controlled. Agencies should maintain logs for recording the location of all disks and tapes at all times. Access to computers tapped into the data should be strictly limited.

c.2) Security of on-line data. Agencies should limit access to the information once it is stored in the computer system. This usually involves the use of passwords. Each password allows the user to get deeper into the system, depending on his/her authorization to have that level of information. Security is maintained if each user knows only the passwords that allow access to the information that the user has a legitimate need for.

c.3) Use of identifiers to mask personal identities. Agencies should identify individuals whose information is in the system by codes such as agency-assigned identifying numbers, not by personal names. In theory, only one person knows the true identity of the person, the person who enters the information initially into the computer and assigns an identifier.

d. Train staff carefully.

The importance of staff training in this area cannot be overstated. Automated systems make so much more confidential information potentially available to so many more workers that the need for regular and comprehensive training is much greater.

e. Provide notices to clients.

Clients should receive notices stating that certain information about them is being recorded on an automated data system and that it will be accessible to others for specific purposes. The notice should specify the type of information entered into the system, the particular individuals or agencies who will have access to the information, the reasons for which they may have access to the information, and the uses they may make of the information. If the information can be shared among agencies, pursuant to a statutory provision or an interagency agreement, a general notice to this effect may be sufficient. If the information sharing requires the client's consent, the agencies could develop a common consent form that the client can sign only once.

### III. Guidelines and Models (cont.)

#### ***B. Guidelines for Protecting Confidential Student Health Information***

This is a brief document prepared by the National Task Force on Confidential Student Health Information and published in 2000. It was developed as a project of the American School Health Association in Collaboration with the National Association of School Nurses and the National Association of State School Nurse Consultants.



Section I of the document discusses ethical responsibilities and legal obligations.

Section II recommends 8 guidelines and discusses each in detail. The eight are:

- Distinguish student health information from other types of school records.
- Extend to school health records the same protections granted medical records by federal and state law.
- Establish uniform standards for collecting and recording student health information.
- Establish district policies and standard procedures for protecting confidentiality during the creation, storage, transfer, and destruction of student health records.
- Require written, informed consent from the parent and, when appropriate, the student, to release medical and psychiatric diagnoses to other school personnel.
- Limit the disclosure of confidential health information within the school to information necessary to benefit students' health or education.
- Establish policies and standard procedures for requesting needed health information from outside sources and for releasing confidential health information, with parental consent, to outside agencies and individuals.
- Provide regular, periodic training for all new school staff, contracted service providers, substitute teachers, and school volunteers concerning the district's policies and procedures for protecting confidentiality.

\*Published by the American School Health Association.

### III. Guidelines and Models (cont.)

#### **C. Documentation of Psychotherapy by Psychiatrists\***

##### **I. Conflicting Principles and Priorities**

The issues considered in the following paragraphs highlight potential conflicts between two important principles. On the one hand, medical-legal principles indicate that the medical record should be complete, factual, and accurate. On the other, the growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record lest this expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in every individual clinical situation must be free to use their judgment in facing this dilemma. What follows is a consideration of the issues involved; it is not a standard and is not binding on members of the APA.

Documentation of any medical procedure serves multiple purposes and is generally required by state statute, case law, and/or the bylaws of health care organizations. Documentation is a medical and legal record of assessment, decision-making, general management, and specific medical treatment. It should be factual, legible and accurate. The record traditionally serves to facilitate continuity in the care of the patient by the treating psychiatrist or successors. Secondly, with the patient's specific written, informed consent, the medical record can also be referenced to verify that services actually took place or to evaluate "medical necessity" of services rendered for purposes of claiming third party payment. (Such usage of a detailed record of psychotherapy is, however, considered by many practitioners to be incompatible with the practice of psychotherapy.) Furthermore, the medical record may become evidence in litigation for a variety of forensic purposes, including professional liability, where documentation may make a significant difference in the exposure of the treating psychiatrist to liability (Psychiatrists' Purchasing Group, 1994).

Despite ethical standards and varying degrees of legal protection of confidentiality of the doctor-patient relationship, medical records may be open to disclosure in unanticipated ways that are beyond the control of the patient or the psychiatrist, as in the case of mandated reporting laws or other statutory exceptions to confidentiality. Such potential intrusions may present risks to the integrity of psychotherapeutic treatments. The psychiatrist should use all available legal means to protect the confidentiality of any record of psychotherapy.

Psychiatric treatment, especially psychotherapy, involves sensitive, personal information about the patient and other people in the patient's life. The patient reveals this information to the psychiatrist in the faith and trust that it will be used to advance the treatment and that no information from that treatment will be revealed to any other person without informed consent for disclosure. In a landmark ruling pertaining to the admissibility of evidence in Federal courts, the U.S. Supreme Court has explicitly acknowledged that psychotherapy requires an atmosphere of trust and confidence (Jaffee vs. Redmond 116 S.Ct. 1923[1996]).

\*American Psychiatric Association, Commission on Psychotherapy by Psychiatrists, The American Psychiatric Association -- 1400 K Street NW, Washington, D.C. 20005 "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- *APA Operations Manual*.

Originally approved by the Board of Trustees, July 1999. Revised 2001 to integrate compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule promulgated in December, 2000, and effective in April, 2001, with enforcement date of April, 2003. The Commission on Psychotherapy by Psychiatrists (COPP), in consultation with the Committee on Confidentiality, has revised its Resource Document on Documentation of Psychotherapy by Psychiatrists to incorporate the requirements of the HHS Privacy Rule. The Council on Psychiatry and the Law has reviewed the paper and made some modifications acceptable to COPP.

**HHS protection of psychotherapy notes.** This principle was further elaborated in the special protections for psychotherapy notes in the Privacy Rule promulgated by the U.S. Department of Health and Human Services (HHS) in December, 2000, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Mandatory compliance with the rule will take effect in April, 2003. It establishes a special category of protection for psychotherapy notes, which are defined as *“notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, family counseling session.”* The definition excludes “medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis and progress.” (The items excluded from psychotherapy notes are components of the general medical/psychiatric record.) Furthermore, *“to meet the definition of psychotherapy notes, the information must be separated from the rest of the individual’s medical record.”* Notably, psychotherapy notes are still a part of the identifiable record.

Access to these notes is forbidden except with the patient’s specific authorization. Authorization may not be compelled as a condition of health insurance payment or provision of services. Narrow exceptions to this protection include reporting laws (e.g., child abuse), disclosures necessary to prevent harm to the patient or others, supervision for training purposes within the ambit of confidentiality, defense against litigation by the patient, investigation by a medical examiner to determine the cause of death of the patient, health care oversight (investigation of the therapist), and disclosures authorized by the patient. The patient does not have the right to read, amend, or have a copy of psychotherapy notes. The protection continues after the death of the patient, except as noted above.

The APA believes disclosure of psychotherapy notes to third-party payers is not necessary for determining payment or medical necessity; this is consistent with the HIPAA Privacy Rule’s definition of psychotherapy notes. (The reader is referred to APA Resource Document, “Psychotherapy Notes Provision of Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule” (March 2002).

The rationale for special protection of psychotherapy notes is based on the deep trust needed for full disclosure of intimate personal material by a patient for the sole purpose of understanding and benefit within a psychotherapeutic relationship, delineated in *Jaffee v. Redmond*. It is keyed to the patient’s expectations and the process of treatment, not to the procedure code of the service at hand. Therefore, sensitive material disclosed by a patient may be segregated in psychotherapy notes, whether the service is a specifically identified psychotherapy service (e.g., CPT 90805 to 90829, 90845, 90847) or another psychiatric service that the patient would view as establishing or including a “counseling relationship”, such as psychiatric evaluation (CPT 90801) or pharmacological management defined as providing no more than a minimal amount of psychotherapy (CPT 90862). APA’s resource document on Psychotherapy Notes Provision of HIPAA Privacy rule (March 2002), developed by the Committee on Confidentiality and the Council of Psychiatry and the Law, presents a summary and clarification of the regulation insofar as it pertains to psychotherapy notes. The American Psychiatric Association is committed to seeking maximum protection of the confidentiality of psychiatric records. The American Psychiatric Association is committed to seeking maximum protection of the confidentiality of psychiatric records.

The fact that it is now technically feasible to computerize medical records and transmit them electronically may present a greatly increased vulnerability to unauthorized access that may compromise confidentiality and could cause significant harm to the patient. No existing security system absolutely protects electronic records in data banks from human error or malice. Although the same risks pertain to paper records, access to electronic records may be easier to accomplish



and more difficult to detect unless audit trails are maintained, accessible, and monitored. Recording psychotherapy content or process in electronic systems beyond the direct control of the practitioner (and professionals in an organized setting who are collaborating in the patient's psychotherapeutic treatment) would place a patient's private thoughts and acts at such grave risk of unauthorized disclosure as to deter or limit treatment.

Psychotherapy is a crucial part of the training of psychiatric residents. As a part of this training, residents must learn how to document psychotherapy in the medical record while maintaining confidentiality. They need to understand those instances when documentation conflicts with and potentially jeopardizes the confidentiality upon which the effectiveness of the psychotherapy is based. The same emphasis on maintaining confidentiality in documentation should also be addressed in the continuing education of practicing psychiatrists.

***What follows is a suggested format, not a standard of practice,*** for documentation of psychotherapy by psychiatrists. It does not address issues involved in the process of releasing information to third parties, but it considers how the possibility of such release may affect documentation procedures. This discussion does not necessarily reflect current practice of documentation of psychotherapy throughout the profession. Variations occur because of state law and the requirements of individual clinical situations. The extent of documentation may vary from session to session and depends on the treatment method and intensity. A patient and/or a psychotherapist may prefer that there be no documentation, although this can pose significant liability risks to the practitioner because of the absence of contemporaneous documentation that can serve as evidence to support the standard of care provided. It should also be noted that the absence of adequate documentation makes it difficult for another psychotherapist to take over the care of a patient in cases of psychotherapist disability or death. In some states documentation is explicitly required under law.

APA's ethical principles state that "Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient." And, "Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact." The psychiatrist should be mindful of the cautions stated in these principles when writing medical records in general, considering how likely it is that others might view the records and thus become a vehicle for disclosure. Entering any notation of psychotherapy process or content requires even greater circumspection

## **II. Suggested format for documentation of psychotherapy by psychiatrists**

**1. Clinical judgment.** The growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical/psychiatric record in order not to expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in each individual clinical situation must be free to use their judgment in coming to terms with this dilemma.

**2. Variation in documentation procedures.** Variations in documentation procedures may necessarily occur because of state law or the requirements of individual clinical situations. The latter may include a patient's request or the clinician's judgment that there be no identifiable documentation. Possible legal ramifications of avoiding documentation may vary in different jurisdictions.

**3. Initial evaluation.** The record of the patient's initial evaluation should accord with generally accepted procedures for conducting and documenting an initial psychiatric evaluation, which are beyond the scope of these recommendations. It is important that the individual clinician use judgment in regard to what information is included in the evaluation report so as not to jeopardize the patient's privacy or confidentiality. An initial evaluation may be done and documented by another psychiatrist. While documentation of the initial clinical evaluation is a part of the general medical/psychiatric record, the first meeting with a psychiatrist is a the introductory experience in



establishing the psychotherapy portion of psychiatric treatment. Therefore, personal information revealed by the patient during evaluation for psychotherapy may be recorded in the psychotherapy notes, subject to the definitions and exceptions that are elaborated in the HHS privacy rule.

**4. Concise documentation of psychotherapy while respecting the privacy of the patient's mental life.** Characteristically, the general medical/psychiatric record should concisely record only administrative material regarding the psychotherapy itself, such as the date, duration of the session, procedure code, and/or category of psychotherapeutic intervention (e.g., psychodynamic therapy, supportive therapy, cognitive restructuring, relaxation or behavioral modification techniques, etc.). Depending on clinical judgment, the treatment setting and the security of the patient record in that particular treatment setting, some practitioners may also include a brief mention of major themes or topic(s) addressed, whereas others would consider this an unacceptable risk to the confidentiality of sensitive communications. While scheduled clock times of starting and ending a session or duration of a session may be recorded as an administrative matter if required by third parties, the Commission of Psychotherapy by Psychiatrists believes that actual times of a patient's arrival (e.g., lateness) and departure as determined by the patient (e.g., abrupt departure) are subject matter for the psychotherapy process and therefore should be recorded in the protected psychotherapy notes. If the psychiatrist were investigated for alleged fraud related to time issues, the information and the clinical explanation for the patient's deviation from the scheduled times would be available for defense in the psychotherapy notes. It is important to remember the principles of "minimum necessary" information (see following section). Clinicians should use their judgement about the information that they plan to record in the general medical/psychiatric record, especially in the context of other persons having potential access to this information.

**5. Documentation of psychiatric management.** The general medical/psychiatric record may include other descriptive and historical information, not related to the process or content of psychotherapy, which may provide a record of responsible, diligent psychiatric management and be valuable both to patient care and to the psychiatrist in case of untoward developments. Examples of such information are:

- Clinically important objective events in the treatment setting or the patient's life (e.g., the therapist's unexpected absence, or a death in the family)
- Clinical observations of the patient's mental and physical status (e.g., noting the signs that a patient's depression has improved)
- Changes in diagnosis, DSM or ICD codes, functional status, or treatment plan (e.g., the appearance at new symptoms, return to work, new medication)
- Documentation of the psychiatrist's efforts to obtain relevant information from other sources
- Notation that a patient has been informed and indicated an understanding of the risks and benefits when medication or therapeutic procedures are changed in the course of treatment
- Collaboration with other clinicians
- Changes in the legal status of the patient (e.g., custody, guardianship, involuntary status)
- Other pertinent administrative date.

Legal reporting requirements or the need to justify hospitalization or protective intervention may necessitate documentation of information indicating danger to the patient or others, such as suicidal ideation with intention to act, child abuse, or credible threats of harm to others. The record would generally include basic management information that could enable other clinicians to coordinate effective care by a psychiatric treatment team or to maintain continuity of care if necessary. However, a responsible professional approach in today's world is to consider and justify the necessity of recording each item.

The HIPAA privacy rule mandates that disclosure of medical records information be limited to the minimum necessary to accomplish the purpose of the disclosure. The reader is referred to the APA Position Statement, Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment (December, 2001) when anticipating possible disclosure to third party payers. The psychiatrist may wish to consider organizing the documentation of psychiatric management in such a way that notations of minimum necessary information can be easily extracted from the rest of the record.

**6. *Psychotherapy Notes.*** Intimate personal content, details of fantasies and dreams, process interactions, sensitive information about other individuals in the patient's life, or the psychiatrist's personal reactions, hypotheses, or speculations are not necessary in a formal medical/psychiatric record. Before charting such material the clinician should carefully consider the potential vulnerability of the record to disclosure and misinterpretation. In any case, such notations, if recorded at all in identifiable form, should be confined to the protected psychotherapy notes as defined and designated by the HHS privacy rule.

**7. *Information systems considerations.*** Information entered into a computerized system that goes beyond the direct and immediate control of the treating psychiatrist (and, in an organized treatment setting, of the professionals who are collaborating in the patient's care) should be stringently restricted to protect patient privacy and confidentiality. It must be limited to the minimum requirements of the system for administrative and basic clinical data and not jeopardize the essential privacy of psychotherapy material. As with any disclosure of medical records, paper or electronic, transmission of detailed clinical information to information systems outside the treatment setting must not occur without the awareness and specific, voluntary, specifically defined, written consent of the patient. Psychiatrists, along with their patients, should have the right to decide together to keep information from psychotherapy out of any computerized system. If kept on a computer, unless the patient specifically authorizes disclosure to others.

**8. *Psychotherapy with Medical Evaluation and Management.*** The APA and the Commission of Psychotherapy by Psychiatrists affirm that psychiatrists' medical training, experience, and assessment and management skills are integral to their ongoing psychotherapeutic work. However, certain CPT codes in the 908xx series specifying "Psychotherapy with Medical Evaluation and Management (E&M)" have been interpreted by APA's experts on coding to require specific documentation that in each session thus coded the physician 1) *assessed* the patient's condition through *history-taking and examination* and/or 2) carried out *medical decision-making* and/or 3) provided *management services*. The medical E&M service(s) may optionally be described under a separate heading from the psychotherapy service. Writing a prescription is only one of many possible actions fulfilling this requirement. Documentation may include mental status or physical observations or findings, laboratory test results, prescriptions written (dates, dosages, quantities, refills, phone number of pharmacy, etc.), side effects or rationale for changes of medication, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic procedure, compliance with medication regimen and clinical response, etc. A minimal number of E&M activities may suffice. At this time, it appears that the medical evaluation and management service (as distinct from the psychotherapy service) rendered under the "Psychotherapy with Medical E&M" codes is comparable to a Level One service under the general E&M codes (992xx) available for use by all physicians. Level One assessment could consist of one element of the mental status examination, a vital sign, or an observation of musculoskeletal status.

Documentation requirements for the general E&M (992xx) codes are still in flux. Third parties, such as Medicare, insurance companies, and HMO's are still in the process of developing policies on the kind of documentation they may require to reimburse patients and/or pay practitioners for CPT codes for "Psychotherapy with Medical E&M" (908xx). The APA will work hard to ensure that these new standards conform with APA recommendations for documentation of psychotherapy by psychiatrists. The contents of the psychotherapy portion of a Psychotherapy with E&M service should be documented in the protected psychotherapy notes in accordance with the principles stated above. The medical E&M portion belongs in the general medical/psychiatric record.

**9. *Consideration of patient access to records.*** Psychiatrists should be cognizant of and sensitive to the fact that patients have access to their medical records in many jurisdictions. State law may require release of the record to another physician or health care professional caring for the patient or to the patient's attorney, pursuant to valid written authorization by the patient. The HIPAA rule mandates that patients may view and submit corrections to their general medical record, but

psychotherapy notes are excluded from this mandated access by the patient unless the record is involved in litigation.

**10. Psychiatrist's personal working notes: an unresolved dilemma.** In keeping with the APA Guidelines on Confidentiality (1987) and some authorities on psychiatry and the law (Appelbaum and Gutheil, 1991), the psychiatrist may make personal working notes, unidentified and kept physically apart from the medical record, containing intimate details of the patient's mental phenomena, observations of other people in the patient's life, the psychiatrist's reflections and self-observations, hypotheses, predictions, etc. Such personal working notes are often used as a memory aid, as a guide to future work, for training, supervision or consultation, or for scientific research that would not identify the patient. Many psychiatrists consider such uses to be crucial to the clinical care they provide. *If such notes are written, every effort should be made to exclude information that would reveal the identity of the patient to anyone but the treating psychiatrist.* If there is any risk of disclosure, patients should be informed in a general way about the use of notes for teaching and research and the ways in which identifiable disclosures will be avoided, and the patient's consent should be obtained for such uses. As long as personal working notes are not identifiable and are not part of the patient's medical record, they are not covered by the HHS regulations.

Psychiatrists should be aware, however, that these notes might be subject to discovery during litigation, unless specifically protected by state statute. Even in protective jurisdictions the definition of personal working notes may be challenged and the notes could be subject to judicial review. It is likely that they would be considered privileged in federal judicial procedures covered by *Jaffee v. Redmond*, and in state courts that follow an approach similar to *Jaffee*. If the court does not quash the subpoena on the ground that the material is privileged, the judge would probably review it *in camera* and select what is relevant to the case at hand. *Destroying such notes after a subpoena arrives opens the psychiatrist to extreme legal risk and should never be done. Personal working notes should be destroyed as soon as their purpose has been served, and this should be done in a systematic, routine way for all cases that clearly is not designed to avoid discovery in a specific case.* Psychiatrists should acquaint themselves with the prevailing law affecting personal working notes in their state. The presence or absence of notes is unrelated to the issue whether or not the psychiatrist will be required to testify.

**11. Final clinical note.** A final clinical note at the end of treatment may summarize the psychotherapy concisely in the general medical record from a technical standpoint without divulging intimate personal information, and document the patient's status and prognosis, reasons for termination, and any recommendations made to the patient regarding further treatment and/or follow-up. It is important that the individual clinician use judgment in regard to what information is included in the final report so as not to jeopardize the patient's privacy or confidentiality.

**12. Special situations.** Special documentation requirements established by reputable professional organizations for use by members of those organizations may apply to specified treatment methods or clinical situations. An example is The American Psychoanalytic Association's Practice Bulletin on "Charting Psychoanalysis" (American Psychoanalytic Association, 1997.)

## REFERENCES

- American Psychiatric Association (1987). Guidelines on Confidentiality, *American Journal of Psychiatry* 144:11. Reprint available on request from the APA or at [www.psych.org](http://www.psych.org).
- American Psychoanalytic Association (2001). Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment. Reprint available on request from the APA or at [www.psych.org](http://www.psych.org).
- American Psychoanalytic Association (2002). Psychotherapy Notes Provision of HIPAA Privacy Rule. Reprinting available on request from the APA or at [www.psych.org](http://www.psych.org).
- American Psychoanalytic Association (1997). "Charting Psychoanalysis", *Journal of the American Psychoanalytic Association*, 45:656-672. Available on request from the American Psychoanalytic Association.

- Appelbaum, P., and Gutheil, T. (1991). *Clinical Handbook of Psychiatry and the Law*, 2<sup>nd</sup> Ed., Williams and Wilkins. *Jaffee v. Redmond* 116 S.Ct.1 923[1996]
- MacBeth, J.D.: "Legal Issues in the Treatment of Minors." In Schetky, D.H. and Benedek, E.P.: *Principles and Practice of Child and Adolescent Forensic Psychiatry*. Washington, D.C." American Psychiatric Press, 2001.
- Melonas, J. (1999). "Confidentiality in the Era of Managed Care", *Psychiatric Practice and Managed Care*, 5(1, Jan./Feb.):6-8,12, American Psychiatric Association, Office of Healthcare Systems and Financing
- Psychiatrists' Purchasing Group, Inc. (1994). "Psychiatric Records." in *Legal and Risk Management Issues in the Practice of Psychiatry*, Chapter 7, pp. 1-7.
- U.S. Department of Health and Human Services. (2000). *Final Standards of Privacy for Individually Identifiable Health Information*. (Summary available at [www.psych.org/advocacy\\_policy/leg\\_issues/privacy/finalprivacyregulation1401.pdf](http://www.psych.org/advocacy_policy/leg_issues/privacy/finalprivacyregulation1401.pdf)).



### III. Guidelines and Models

#### *D. Protocol for handling issues of confidentiality in public schools*

#### **From: Confidentiality-Protocol for Issues of Confidentiality in Public Schools**

Prepared by The Manitoba Teachers' Society <http://www.mbteach.org/confidentiality.htm>

Note: While the following was prepared for schools in Manitoba, Canada, most of the points are relevant to all schools.

#### **Article 1. Understanding confidentiality:**

Confidentiality is the obligation not to disclose willingly any information obtained in confidence. Therefore, information disclosed in response to a search warrant, a subpoena or a legal requirement for mandatory reporting is not a breach of confidentiality.

Child protection:

- The teacher who has reason to believe that a child is or might be in need of protection shall forthwith report the information to the appropriate authorities in accordance with legal obligations pursuant to child protection legislation.

Potential harm:

- If the behaviour of the student threatens potential harm to him/herself or another person, the teacher shall take appropriate action to protect the student and/or the other person.

Legal action:

- The teacher may be required by the courts to provide records and relevant information regarding a student.

#### **Basic principles:**

Confidentiality is based on four basic principles:

1. Respect for an individual's right to privacy.
2. Respect for human relationships in which personal information is shared.
3. Appreciation of the importance of confidentiality to both individuals and society.
4. Expectations that those who pledge to safeguard confidential information will do so.

Confidential information in its broadest form is any information given in confidence to a teacher. Confidential information may include, but is not restricted to, disclosures of physical, mental or emotional abuse; family problems; substance abuse; criminal behaviour; sexual activity; or suicidal thinking.

A teacher respects the confidential nature of information concerning students and may give the information only to authorized personnel or agencies directly concerned with the students' welfare.

#### **Article 2. Protecting confidentiality**

Confidentiality is very important to establishing and maintaining a strong teacher-student relationship. It is important that teachers are aware of the rights of individuals to privacy and to respect the confidential nature of information concerning students. A teacher, however, may consult and collaborate with other professionals for purposes of more effectively helping the student.



**Some guidelines for protecting confidentiality are:**

1. A teacher shall consult with the student and attempt to obtain the consent of the student before divulging confidential information.
2. A teacher may consult and collaborate with other professionals for purposes of more effectively helping the student. The teacher shall share only such information that will serve the student's best interests, and divulge the student's name only when necessary.
3. A teacher shall share information verbally with other professional colleagues rather than giving them copies of notes and ensure that colleagues respect the confidential nature of the information being shared.
4. A teacher shall take care, when sharing information about students that the information is accurate and unbiased.
5. A teacher shall guard against sharing confidential information in halls, staff rooms or other public places where persons who do not need to know can overhear it.
6. A teacher shall not leave reports, student service records, computer files or log books where unauthorized people can have access to them.
7. A teacher who is in doubt as to the reasonableness of a course of action regarding the sharing of confidential information should consult the school counselor or school administrator before making a decision.

***Article 3. Record keeping***

A teacher shall keep accurate and objective records to facilitate the provision of services to students. Failure to keep records is negligence. There are no risks to having good records—well-organized, well-written, comprehensive notes will establish the teacher as a competent, caring professional.

Personal records are kept by a teacher to refresh his/her memory and to document important information regarding students for use in consultation, referrals, case conferences and court proceedings. A teacher should record enough information to meet students' needs and to demonstrate effectively that she or he has acted in an appropriate and professional manner.

Notes should be made as immediately as possible to the time of the event(s), and the original notes should never be changed. Any additions should be initialled, signed and dated.

A teacher shall make the student aware that confidential information is being recorded, share such information with the student, clarify the information and inform the student of the possible need to report such information for legal or professional purposes.

***Article 4. Maintaining records***

Schools/school divisions should develop policies and procedures for the maintenance of records, including in such policies provisions for:

- Physical security of records
- Access to records
- Periods of maintenance for different types of records
- Destruction of records.
- Teachers must take care that their personal records are kept in secure locations.

***Article 5. Requests for information***

Schools should develop procedures to ensure that the confidentiality of material is maintained when it is being received or sent by the school. A teacher must keep the best interests of the student in mind when making decisions to divulge confidential information. A teacher shall consult with the student and attempt to obtain the consent of the student before divulging confidential information to authorized personnel or agencies directly concerned with the student's welfare.

The teacher should be aware of the legalities regarding the sharing of information with



parents/guardians. The (Manitoba Public Schools) Act states, in part, that: Every school board shall...

- ...determine the times when and the manner in which reports and other information respecting pupils shall be delivered or provided or made available by teachers;
- ...set out the procedures for the collection, storage, retrieval, and use of information respecting pupil files.

The school/school division should develop policies and procedures for the sharing of information regarding court orders or other legal restrictions on the sharing of information about a student.

Teachers should be aware of all court orders regarding custody of students in their care, and any policies regarding the rights of non-custodial parents to information and access to a child. If non-custodial parents or other individuals involved with the student request information or access, a teacher should refer questions or concerns to the school administrator.

No information should be given without a documented request.

Schools should develop procedures to ensure that the confidentiality of material is maintained when it is being received or sent by the school. Particular care should be taken when giving information by phone or by fax.

#### ***Article 6. Legal proceedings***

A teacher must never destroy records of confidential information.

Records that may be required in court proceedings should be maintained indefinitely, both to assist the student and to prove that the teacher acted responsibly.

The teacher should be aware of divisional policies regarding sharing of information with legal authorities. Information should not be given without a subpoena or a court order (e.g. search warrant).

There is no inherent right of a probation officer or the police to confidential information unless they have a search warrant. If police are executing a search warrant in the school, teachers should cooperate and immediately inform the administration. If a teacher receives a subpoena requesting records, the teacher should inform administration and seek legal advice as soon as possible. The teacher should not automatically turn over records because the subpoena may be challenged as not serving the best interests of the student. The teacher should be aware that keeping records secret or storing them out of the school does not protect them from a subpoena which usually asks for all records kept under all circumstances in any location.

It is important to be aware that the law holds us responsible for our decisions. The defense of “following regulations or policies” does not alleviate a teacher’s accountability in making appropriate decisions about a student.

#### ***Article 7. So what if you don't agree?***

Teachers have a professional obligation to protect confidences. They also have the obligation to act in a professional manner in their interactions with students, and with their peers.

School Divisions should develop procedures whereby a teacher can comply with this protocol without breach of confidentiality, or refuse to provide the information without being subject to disciplinary action by the division. A conflict may arise when there is a demand by the police or school administration to have confidential information released with which a teacher is reluctant to comply because doing so would violate this protocol. The teacher should immediately seek advice from appropriate sources.

When in doubt, the teacher should:

- >remember that confidentiality resides with the student
- >advise administration
- >request help
- >know the pertinent laws and regulations
- >be accountable for decisions regarding students
- >above all, act professionally

### III. Guidelines and Models

#### ***E. Protecting the Privacy of Student Records***

Excerpted from *Protecting the Privacy of Student Records: Guidelines for Education Agencies*

Oona Cheung, Barbara Clements, Ellen Pechman

Prepared for the National Forum on Education Statistics under the National Center for Education Statistics,  
U.S. Department of Education

pages 30 and 1-5 from <http://nces.ed.gov/pubs97/97527.pdf>

The protection of Pupil Rights Amendment (PPRA), 20 U.S.C. 1232h, applies to programs that receive funding from the U.S. Department of Education. The law was amended under the “Goals 2000: Educate America Act” on March 31, 1994. The Department issued a Notice of Proposed Rulemaking on August 28, 1995, to reflect changes in the law. Final regulations are expected in early 1997.

PPRA is intended to protect the rights of parents and students in two ways:

- It seeks to ensure that schools and contractors make instructional materials available for inspection by parents if those materials will be used in connection with a Department of Education-funded survey, analysis, or evaluation in which their children participate; and
- It seeks to ensure that schools and contractors obtain written parental consent before minor students are required to participate in any Department of Education-funded survey, analysis, or evaluation that reveals information concerning:

1. Political affiliation;
2. Mental and psychological problems potentially embarrassing to the student and his/her family;
3. Sex behavior and attitudes;

4. Illegal, anti-social, self-incriminating and demeaning behavior;
5. Critical appraisals of other individuals with whom respondents have close family relationships;
6. Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers; or
7. Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

Parents or students who believe their rights under PPRA may have been violated may file a complaint with the Department of Education by writing the Family Policy Compliance Office. Complaints must contain specific allegations of fact giving reasonable cause to believe that a violation of PPRA occurred.

For additional information or technical assistance, you may call (202) 260-3887 or TDD (202) 260-8956 or contact:

Family Policy Compliance Office  
U.S. Department of Education  
600 Independence Avenue, SW  
Washington, D.C. 20202-4605

## ***SUMMARY OF KEY FEDERAL LAWS***

### ***OVERVIEW***

Students and their parents entrust schools with their personal information with the expectation that this information will be used by the schools to serve the needs of the students effectively and efficiently. School districts maintain and use personal information for a variety of educational purposes while students are in school. To protect the privacy of the students and their families, agency and school staff are legally and ethically responsible for safeguarding student information.

Many federal and state laws and regulations, which must be followed, relate to maintaining and releasing student information. However, education agencies need additional policies and procedures to guide their everyday operations to maintain the information. Since agencies vary in how they collect and maintain information about students, the types of policies and procedures needed also will vary. This document provides examples of policies and procedures as well as guidelines for deciding what is needed to ensure the privacy of student information.

Section 1 presents an overview of the principles related to the privacy of student records, explains key concepts, defines important terms, and describes the uses and organization of this document.

### ***PRINCIPLES AND CONCEPTS***

#### **A. Principles Underlying Privacy Protections**

To protect the privacy of families whose children are in school, states and the federal government have established strong legal statutes to keep private the information in education records that schools maintain on students. These laws frame data collection procedures, restrict information disclosure, and safeguard the quality of the information that school systems routinely collect and maintain. All education records about students, whether handwritten or computerized, are protected by the same privacy regulations. Education personnel are responsible for protecting the integrity and accuracy of the information they gather and maintain. Therefore, data managers, their staff, and other agency and school personnel, must become familiar with the laws that ensure the confidentiality of the records as well as the legal concepts underlying those laws.

Education records contain the administrative reports of students' educational progress, along with any information about past or current use of school-related services, such as special education, social work services, or other supplementary educational support. The Family Educational Rights and Privacy Act (FERPA), a federal law, limits who can see an education record without the consent of the student's parent, and it provides for a parent's right to see what is kept in the records. These two basic features have broad implications for the treatment of information about students by teachers, administrators, and researchers.

In addition, schools that participate in a federally assisted school nutrition program have personal information about students' eligibility for free and reduced-price school meals or free milk. These programs have regulations that are more restrictive than FERPA's regarding the disclosure and use of this information. In cases of emergency, school officials can obtain data in education records to help students or their families get the assistance or care they need.

In addition to the everyday use of student information by teachers and administrators, education records are a source of basic data used for administrative purposes and policymaking. Statistical information summarized from education records can be an important resource for monitoring programs and for evaluating the success or failure of education policies. Administrative use of computerized records means that education records are used increasingly farther from their point of origin. As a result, it has become more complicated but no less essential for school officials to be vigilant about protecting the confidentiality of records. Those who work with education records have legal and ethical obligations to observe rigorous procedures for protecting the privacy of the original information and the individuals whose records are involved.

The Information Infrastructure Task Force of the *National Information Infrastructure* (NII) recently developed a set of principles for providing and using personal information. These principles, summarized in *Exhibit I-1*, provide guidance for those who are drafting laws and regulations or creating codes of fair information practices and implementation procedures. The principles apply to both the private and public sectors. The guidelines presented throughout this document are consistent with the NII principles.

## **B. Key Concepts of Privacy Laws and Confidentiality Policies**

Privacy laws lead to establishing regulations that education agencies and schools must follow so that information about children is available only to officials who are authorized to know such information. The laws were passed by the U.S. Congress to ensure parents the right of access to information about their children, while allowing education officials the flexibility they need to use the information in making decisions that serve children well.

Federal and state privacy statutes pertaining to students in elementary and secondary schools build on concepts of common law and privacy guarantees found in the *U.S. Constitution*. Fundamental to the government's rulemaking about data collection, privacy, and appropriate use are three concepts--notification, disclosure, and informed consent.

**Notification** (according to FERPA) refers to an agency's responsibility to inform parents, guardians, or students who are over eighteen of the legal basis for compiling data and the limited circumstances under which records can be released or disclosed. When school officials collect information about families or students, they must explain the rationale--or "give public notice"--of the reasons the data are being collected.

**Disclosure** refers to access, release, or transfer of personal information about individuals. Privacy laws define appropriate or inappropriate information disclosures or releases. According to FERPA, data about students may be disclosed without parental consent only to school and other education officials who use it to provide educational services or to carry out legally specified administrative and statistical activities. Any instance in which unauthorized individuals see or use private information about students is an inappropriate and often illegal disclosure, unless the parent or the student gives consent or the law makes such access legal.

**Informed consent** involves providing a written account of why personal information is requested and how it will be used. In general, parents should have the option, without penalty, of agreeing or declining to provide the information an education agency or school requests. Certain information, however, is required by schools, and parents must provide the information in order for their children to be enrolled. Parents' agreement must be based on an understandable explanation of how the information will be used. Once a parent's informed consent is given for a particular purpose or set of purposes, the information cannot be "rediscovered"--used by a third party--except as originally indicated. FERPA regulations require that prior consent be given by parents for the disclosure of information to persons other than school officials.

## **C. Important Terms**

**Education Record:** An *education record* is a compilation of records, files, documents, and other materials that contain information directly related to a student and maintained by education agencies or institutions, or by individuals acting on behalf of the agencies. According to FERPA, a record means any information recorded in any way, including, but not limited to, handwriting, print, computer media, video or audio tape, film, microfilm, and microfiche. An education record, sometimes referred to as a student record, may include a variety of details about a student such as the date of birth, date of enrollment, bus route, immunization history, achievement test scores and grades, enrollment and attendance, awards, degrees achieved, and special education plans and evaluations. Personal notes by teachers or other staff that are not meant to be shared are not part of an education record. A record of a student may be maintained in more than one location within an agency or school (e.g., enrollment record in the school's administrative office and health information in the school health clinic).

Information included in an education record is collected primarily from the student (or family members), teachers, and other school staff. It may also be collected from other sources outside the school, such as health care providers or testing companies. Personal information about students is a vital resource for teachers and school staff in planning responsive education programs and services--designing individual education plans; scheduling students into appropriate classes; planning school bus routes; and completing reports for local, state, and federal authorities. In emergencies, the information is readily available to school officials to assist students and their families. A limited amount of this information, as defined by the school district or the state, makes up a student's permanent records or transcripts.

**Confidentiality:** *Confidentiality* refers to your obligation not to disclose or transmit information to unauthorized parties. Confidentiality extends to information about either individuals or organizations. In schools, districts, or state education agencies, that usually means establishing procedures that limit access to information about students or their families. This access extends to the school officials who work directly with the students, agency representatives who serve as evaluators or auditors, or individuals who act on behalf of authorized education officials.

**Privacy:** *Privacy* is a uniquely personal right that reflects an individual's freedom from intrusion. Protecting privacy means ensuring that information about individuals is not disclosed without their consent. A student's right of privacy is violated when personal information is disclosed to others without consent, or when he or she is being asked for personal information by others who have no legal basis to do so. While *confidentiality*, defined above, refers to restricting disclosure of information to authorized individuals only, *privacy* refers to protection from personal intrusion.

**Security:** *Security* refers to technical procedures that ensure only the authorized and intended parties have access to data.

**Disclosure (or Release):** *Disclosure* includes permitting access to, revealing, releasing, transferring, disseminating, or otherwise communicating all or any part of any individual record orally, in writing, or by electronic or any other means to any person or entity. The terms disclosure and release are used interchangeably in this document. Throughout this document, the information being disclosed or released pertains to students and/or their families.

**Parent or Eligible Student:** FERPA grants parents the rights to review, request amendment to, and release education records. A *parent* means a natural or adoptive parent, a legal guardian, or an individual acting as a parent in the absence of the parent or guardian. These rights transfer to *eligible students* when they reach eighteen or when they attend a postsecondary education institution. However, parents can still have access if the *eligible student* is a dependent for tax purposes. When used in this document, the term parent refers to the person who is given the rights described in FERPA.

**Agency or School:** Throughout this document, *agency* or school refers to the entity that collects, maintains, uses, and releases information from education records. This entity may be a state education agency, school district, public or private school or institution, intermediate education unit, or an institution to which funds have been available to administer an educational program for students with disabilities or schoolwork programs administered on behalf of an education agency.

## References

Information Infrastructure Task Force. 1995. *Privacy and the national information infrastructure: principles for providing and using personal information*.

National Forum on Education Statistics. 1994. *Education data confidentiality: two studies*. Washington, DC: Government Printing Office.

Russell, D., and Gangemi, G.T. Sr. 1991. *Computer security basics*. Sebastopol, CA: O'Reilly & Associates, Inc

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Washington, DC 20006



### III. Guidelines and Models (cont.)

#### **F. Confidentiality in schools: Do you know what to do?**

A discussion of limitations to confidentiality, standards of professional organizations and legal regulations By Monica Pires

<http://www.apadivisions.org/division-16/publications/newsletters/science/2012/07/confidentiality-in-schools.aspx>

**Abstract:** School settings can generally pose several challenges for maintaining confidentiality. Due to the varying roles school psychologists assume (e.g., evaluator, counselor, and consultant), it may be unclear when and what information should be kept confidential. Although students are entitled to confidentiality rights, parents are also given access to this information. Furthermore, school educators such as teachers and principals may request disclosure of what may be considered confidential information. Understanding confidentiality within school settings is critical to good school psychology practice. Limitations to confidentiality, standards of professional organizations, and legal regulations are discussed.

The competing interests and obligations that school psychologists have to students, parents, teachers, and administrators can make confidentiality in school settings difficult. School psychologists rely on other professionals and families when planning for student services. They often request and disseminate information to help their students; however, in some instances, it may be unclear when and under which circumstances the ethical standards of confidentiality apply.

Confidentiality refers to the ethical obligation to conceal information obtained through a professional relationship (Jacob & Hartshorne, 2007). The National Association of School Psychologists—*Principles for Professional Ethics* (2000) and the American Psychological Association—*Ethical Principles of Psychologists and Code of Conduct* (2002) have outlined confidentiality standards for school psychologists to follow. School psychologists are held to a standard whereby they are expected to “respect the confidentiality of information obtained during their professional work. Information is revealed only with the informed consent of the client, or the client’s parents or legal guardian, except in those situations in which failure to release information would result in clear danger to the client or others” (NASP-PPE, III, A, #9).

All information revealed to school psychologists as individuals receive services (e.g., counseling or consultation) is therefore protected, unless concealing that information would result in “clear danger.”

In schools, an added complexity exists since students are entitled to confidentiality rights; however, because they are minors parents are given the right to access information regarding the services received by their children (Jacob, 2008).

This is particularly important in the case of direct service delivery (such as counseling), which may affect professional practice. Isaacs and Stone (2001) found that often adolescents feel reluctant to participate in counseling because they do not have the same entitlement as adults do. Consequently, building a therapeutic relationship with the child or adolescent may become difficult, as some information intended to not be disclosed will have to be shared with parents. Nonetheless, school psychologists should explain to parents the importance of confidentiality and seek parents’ agreement to only inquire about general information (Jacob & Hartshorne, 2007). A trusting relationship needs to be built in order to effectively help children and adolescents reach positive outcomes.

In addition, school psychologists should inform parents that they will communicate with them immediately should they become aware of a serious situation. Parents should be informed about issues concerning sexuality, pregnancy, physical or sexual abuse, substance abuse, crimes against property, and danger to self or others (Isaacs & Stone, 2001). Reassuring parents that they will be



informed of serious situations is important to establish trust and strengthen home-school collaboration.

Otherwise, keeping parents informed with brief summaries of sessions should be sufficient.

Limits of confidentiality should be discussed at the beginning of services, unless the student was referred for an evaluation to determine if he or she is a threat to self or others (Flanagan, Miller, & Jacob, 2005). Students and parents should know from the beginning of services that the school psychologist is there to help and will do everything he or she can that is in the best interests of the student. If at any point the school psychologist determines that confidentiality must be breached, explaining to the student the reasons for disclosure becomes an important part of the process. It is also best to collaborate with the student when sharing confidential information (Isaacs & Stone, 2001). This should ease the process and empower the student to problem-solve and engage in decisionmaking. It also promotes autonomy and strengthens trust between the school psychologist and the student. Only information that is crucial to understanding and resolving the situation should be shared (Davis & Sandoval, 1982).

There are three situations in which school psychologists are obligated to disclose confidential information: 1) if the student makes the request, 2) if there is a situation involving danger to the self or others, or 3) if it is mandated by law (Jacob & Hartshorne, 2007). Fisher (2009) explained that school psychologists have the legal duty to protect others from foreseeable danger (e.g., suicide and sexually active HIV individuals) and the legal duty to protect all students attending their school from possible harm (e.g. student-on-student violence). Duty to warn and protect laws usually require that third party individuals be informed of potential harm, so that such individual can seek safe environments.

Nevertheless, in legal settings confidential information is classified as ““privileged communication.”” In other words, information shared with the intent of helping a client or in a professional relationship is not subject to disclosure (Jacob & Hartshorne, 2007). In school settings, this right to privacy is given to minors and their parents or guardians. There are some exceptions to privileged communication, for example, records or testimony can be subpoenaed by a court of law for cases involving child abuse and criminal acts. When a subpoena requests privileged communications, the school psychologist is obligated to respond and should inform the court that he or she cannot provide privileged information without consent from his or her client (Fisher, 2009). The presiding judge has the power to waive privileged communication, which would then permit disclosure of information. If a school psychologist discloses information without the consent of the client or the waiver of the presiding judge, he or she may be at risk for a malpractice lawsuit (Jacob & Hartshorne, 2007).

Confidentiality issues also arise in consultation and collaboration with others. These are similar to the confidentiality standards for direct services. The school psychologist should maintain confidentiality of all that is said in consultation and collaboration; if this does not occur, the trust that is essential for a safe professional relationship will not emerge.

Just as with direct services, limits of confidentiality and its parameters should also be discussed at the onset of consultation services and collaboration. The consultant may have to explain to others (e.g., administrators) that general impressions may be shared but not specific information (Davis & Sandoval, 1982; Erchul & Marten, 2002). Information obtained through consultation or collaboration is simply to be shared for the purpose of helping the student. Only the minimal information necessary to help should be shared (Jacob & Hartshorne, 2007).

Although at first glance confidentiality may appear to be a simple ethical principle, the application of these ideas can be more complex, especially when working within the constraints of the law. For example, a school psychologist may question what to do if he or she learns of a student who is sexually active or has committed a past criminal act. Generally, school psychologists do not have

a legal duty to report unless, as mentioned earlier, there is a potential for harm to occur. A school psychologist is not required by federal law to report this, however, specific state laws or district policy may differ (Jacobs, 2008). Depending on the situation, school psychologists may be legally obligated to inform parents, authorities, or a public health clinic. In all unclear issues pertaining to confidentiality, school psychologists should consult their state laws and district policies. They may also consult with administrators and the district lawyers.

In addition to the ethical standards of confidentiality, laws exist to protect the privacy of individuals. The Family Educational Rights and Privacy Act (FERPA) of 1974 is a federal law that protects the students' records in all schools that receive federal funding (Fisher, 2009). Consent is needed to allow release of records to others, except in special circumstances (e.g., health, safety, legal request, etc.). Under FERPA, parents, guardians, or an eligible student (age 18 or in post secondary programs) must be informed yearly of their right to access their records and must also receive an explanation of the procedures necessary to access them. Parents can review records such as actual test protocols, including specific test items (Canter, 2001a).

Any educational agency or institution that denies or prevents parents, guardians, or an eligible student the right to access the educational records may no longer receive federal funding (Boomer & Hartshorne, 1995). Furthermore, the Individuals with Disabilities Education Act (IDEA) requires that school districts establish policies and procedures similar to those required by FERPA. School psychologists should be familiar with their specific district policies and procedures for obtaining and disposing of records (Canter, 2001b).

School psychologists are ethically obligated to keep records of their work but are to document only information that is necessary to provide services. As these records are created, stored, accessed, disseminated, and disposed, they are to be protected in accordance with confidentiality standards (APA, Standard 6.02). They must be stored in a secure place, access should be limited to those who need the information to provide appropriate services, identifying information should be removed whenever possible, and disposal of records should take place in accordance with the law when records are no longer needed (Fisher, 2009). Records can take various formats (e.g., written or printed, audio or video recordings, emails, faxes, etc.). School psychologists should consult their local educational laws to know what kinds of information to store, how to store it, and for how long to store it (Jacob & Hartshorne, 2007). For students with disabilities, school records include medical, educational, and psychological information (Canter, 2001b). A psychological record may consist of documents relevant to evaluations, team meeting notes, Individualized Education Plans (IEPs), documents describing interventions, manifestation records, and suspension records.

Confidentiality is an ethical principle to ensure the privacy of clients, whether they are students, parents, teachers, or another interested party. It serves the purpose of preventing improper dissemination of information that may result in bias and fosters an environment of trust and safety. Although applications of confidentiality can be confusing, a strong knowledge base of ethical standards and the law can improve and facilitate the practice of psychological services in schools.

## References

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- Boomer, L., & Hartshorne, T. (1995). Confidentiality and student records: A hypothetical case. *Preventing School Failure*, 39(2), 15.
- Canter, A. (2001a). Test protocols, part I: Right to review and copy. *Communiqué*, 29(7), 30.
- Canter, A. (2001b). Test protocols, part II: Storage and disposal. *Communiqué*, 30(1), 16.
- Davis, J. M. & Sandoval, J. (1982). Applied ethics for school-based consultants. *Professional Psychology*,

13, 543-551.

Erchul, W. P., & Martens, B. K. (2002). *School consultation: Conceptual and empirical bases of practice* (2nd ed.). New York: Kluwer Academic/Plenum Publishers.

Fisher, C. B. (2009). *Decoding the ethics code: A practical guide for psychologists* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Flanagan, R., Miller, J., & Jacob, S. (2005). The 2002 revision of the American Psychological Association's ethics code: Implications for school psychologists. *Psychology in the Schools*, 42(4), 433-445.

Isaacs, M., & Stone, C. (2001). Confidentiality with minors: Mental health counselors' attitudes toward breaching or preserving confidentiality. *Journal of Mental Health Counseling*, 23(4), 342.

Jacob, S. (2008). Best practices in developing ethical school psychological practice. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology V* (pp. 1932-1932). Bethesda, MD: National Association of School Psychologists.

Jacob, S., & Hartshorne, T. S. (2007). *Ethics and law for school psychologists* (5th ed.). Hoboken, NJ: John Wiley & Sons.

National Association of School Psychologists. (2000). *Professional conduct manual*. Bethesda, MD: Author. Retrieved April 6, 2010, from <http://www.nasponline.org/standards/professionalcond.pdf> (PDF, 214KB)





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