



INFORMATION SHARING IN CRIMINAL JUSTICE - MENTAL HEALTH COLLABORATIONS: Working with HIPAA and Other Privacy Laws



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INFORMATION SHARING IN **CRIMINAL JUSTICE-MENTAL HEALTH COLLABORATIONS:**

Working with HIPAA and Other Privacy Laws

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INTRODUCTION

Information Sharing in the Criminal Justice–Mental Health Context

Individuals with mental illnesses are overrepresented at every stage of the criminal justice process. In response, many jurisdictions have developed a range of policy and programmatic responses that depend on collaboration among the criminal justice, mental health, and substance abuse treatment systems.¹ A critical component of this cross-system collaboration is information sharing, particularly information about the health and treatment of people with mental illnesses who are the focus of these responses. At the individual level, health information is essential to provide adequate assessment and treatment. At the program level, it can be used to identify target populations for interventions, evaluate program effectiveness, and determine whether programs are cost-efficient. However, legal and technical barriers, both real and perceived, often prevent a smooth exchange of information among these systems and impede identifying individuals with mental illnesses and developing effective plans for appropriate diversion, treatment, and transition from a criminal justice setting back into the community.

Understanding the legal framework of information sharing is the crucial first step for jurisdictions seeking to design and implement effective criminal justice-mental health collaborations. This guide supports that first step by introducing how federal and state laws are likely to influence practitioners' responses. Federal law shapes what is permissible at the state or local level, primarily through the basic privacy rules for “[protected health information](#)” (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)² and substance abuse treatment information under [42 CFR Part 2](#), a portion of the Code of Federal Regulations addressing public health.*

Because of the importance of and variety in state laws, many specific questions raised by practitioners will require answers from local, county, or state counsel. This document is not a substitute for the advice of an attorney. However, this discussion does provide practitioners with a fundamental understanding of the legal issues expected to be involved with information sharing and how the legal framework is likely to affect their initiatives. Every effort has been made to balance the explanations of the law with the practical guidance that practitioners will find useful.

Before reviewing the specifics of the law, it is helpful to consider the ethical aspects of confidentiality and privacy with regard to health information. The ethical

*All words highlighted in blue are linked to and defined in the glossary.



principles that animate professional responsibility codes, as well as state and federal law, assume that information about mental illness and substance abuse is highly personal and most people would prefer it to remain private. Successful treatment often relies on a relationship of trust between patients and their treatment providers. At the same time, sharing health information can be critical to positive public health and safety outcomes. The federal and state laws generally reflect an attempt to strike a balance between ensuring that private information remains private without compromising the delivery of needed health-care or public safety services.

The Federal Legal Framework for Sharing Health Information

Terminology

HIPAA, together with regulations promulgated by the U.S. Department of Health and Human Services (HHS),* establish federal standards for the privacy and security of PHI,[†] including mental health information. HIPAA includes a “Privacy Rule” and a “Security Rule;” the latter deals with only the security requirements for information technology (IT) systems transmitting health information and is beyond the scope of this guide.³ The American Recovery and Reinvestment Act of 2009 (ARRA) and its Health Information Technology for Economic and Clinical Health (HITECH Act) provisions are, however, relevant to these discussions because they slightly alter enforcement and penalties, as discussed on page 23.⁴

HIPAA’s restrictions on sharing health information are often misunderstood, which has resulted in practitioners’ misapplying the law to be far more restrictive than the actual regulatory language requires. Practitioners should keep in mind the original intent of the legislation, which was to facilitate insurance coverage through the development of an information system for electronic health records that ensured appropriate privacy and IT security. HIPAA was not designed or intended to impede the provision of necessary health services.

HIPAA sets out rules governing how “covered entities” share PHI. This means that HIPAA applies if either the entity requesting information or the entity providing information is a “covered entity,” which is defined as

1. *a health plan;*
2. *a health clearinghouse;*

*In keeping with common usage, unless otherwise indicated, “HIPAA” refers to both the Health Insurance Portability and Accountability Act and the related HHS regulations, which appear in the Code of Federal Regulations at 45 CFR 160, 162, and 164.

[†]The definitions for “PHI” in HIPAA and the information protected under 42 CFR Part 2 are provided in the glossary. For the purposes of this guide, PHI refers to information protected under either of these legal authorities.



3. *a health-care provider who transmits any health information in electronic form in connection with a transaction [relating to health claim report, status, payment, etc.].*⁵

This guide is organized to help practitioners determine whether their organization or an organization with which they seek to communicate is a covered entity.

For entities dealing with substance abuse treatment, an additional set of federal regulations applies: 42 CFR Part 2* concerns the confidentiality of alcohol and drug abuse patient records.⁶ These regulations apply to all “**programs**” that are “**federally assisted**.”⁷ A program is defined as

1. an individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
2. an identified unit within a general medical facility that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
3. medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers. [Examples are provided in the regulations.]⁸

For example, this definition means that XY Hospital would not be a “program,” but the Substance Abuse Unit of XY Hospital would be a “program” because its primary function is providing substance abuse diagnosis and treatment.

Programs that are “federally assisted” derive some benefit from the U.S. government, such as accepting Medicaid or receiving nonprofit status under the federal tax code. Under the regulations, programs are considered federally assisted if they are conducted by a U.S. department or agency, are being carried out under authorization granted by a U.S. department or agency (such as Medicare providers, authorized methadone maintenance treatments), or are supported by funds provided by any department or agency of the United States (including state or local government units that receive federal funds that could be used for substance abuse treatment). A program is also federally assisted if income tax deductions are granted to those who contribute to the program or if the program itself is tax exempt.⁹ This definition means that a private practitioner providing alcohol or substance abuse treatment will not fall within the restrictions of 42 CFR Part 2 unless the practitioner meets one of the conditions above, for example, through accepting Medicaid reimbursement.

*The federal legal framework for substance abuse treatment is generally referred to by the regulations “42 CFR Part 2” instead of its authorizing statute, which is now codified at 42 USC, sec. 290 ee–3.



Sharing Information under Federal Law

HIPAA and 42 CFR Part 2 rarely explicitly *prohibit* the exchange of information. Rather, they generally provide guidance about the conditions under which information can be shared. The two sets of regulations also have important differences, though, with HIPAA typically being more permissive about information sharing than 42 CFR Part 2.

The type of permission required for sharing information under these federal laws depends on the answers to the following questions:

1. Is the party sharing the information a “covered entity” (for PHI under HIPAA) or a “federally assisted program” (for substance abuse information under 42 CFR Part 2)?
2. Is the party requesting the information a covered entity or a federally assisted program?
3. What purpose will the shared information serve (e.g., treatment or the search for a fleeing suspect)?

HIPAA sets out different types of permission for sharing information and the circumstances under which they apply. The general rule is that an “authorization” is required;¹⁰ however, if the information is to be shared for the purposes of treatment, payment, or health-care operations, “consent,” which is less specific, may be obtained from the individual but is not required under HIPAA.¹¹ (As noted throughout this guide, although HIPAA does not require consent in these situations, state law may.) There are also limited situations where only “an opportunity to agree or object” is required.¹² Finally, in some situations, the information may be shared for a specific purpose without involving the individual at all,¹³ as in the case of a judicial order.¹⁴ In contrast, 42 CFR Part 2 requires specifically defined “consent” for almost all disclosures of PHI other than emergencies, under court order, and when otherwise required under specific provisions.¹⁵ Although these terms can be confusing, this guide discusses the types of situations criminal justice professionals and clinicians working with the criminal justice system are likely to encounter and provides general direction for determining the necessary permissions.

There are also tools that can be used to facilitate exchanges among agencies that interact regularly, as is often the case in criminal justice-behavioral health collaborations. These include partnerships formed through “business associate agreements” and “qualified service organization agreements.” Agencies in collaborative relationships can create or use forms such as uniform authorization/consent forms and standard judicial orders (see Information-Sharing Tools section).

After the appropriate permission has been obtained, practitioners should generally share the “minimum information necessary for the allowed purpose,” as opposed to sharing all information at their disposal.¹⁶ There is an important exception for health-care providers who are sharing information for treatment purposes, at



the request of the HHS Secretary, for a reason required by law, or who are sharing information with the individual who is the patient or consumer.¹⁷

The Relationship between Federal and State Law

HIPAA and 42 CFR Part 2 set a *minimum* standard for protecting and securing PHI. If state law is more restrictive (i.e., is more protective of privacy) than these federal laws and related regulations, then the state law governs.¹⁸ A local, county, or state counsel can advise whether state law or federal law is more restrictive in a given area. Although practitioners must always be sensitive to the specific facts and applicable laws, the general principles that follow help determine which area of law is likely to apply in a given situation:

1. State law is almost always stricter than HIPAA in providing for the confidentiality of mental health records. Therefore, in determining the legal rules for a particular exchange of mental health information, counsel may want to consider state law first.
2. In contrast, the federal regulations for the confidentiality of substance abuse and alcohol treatment (42 CFR Part 2) are rarely exceeded by state law. Rather, state laws usually mirror the federal regulations. Therefore, in determining the legal rules for a particular exchange of substance abuse or alcohol records, federal law usually will be the starting point for the analysis.

This means that in treatment programs working with individuals with co-occurring mental and substance use disorders, 42 CFR Part 2 will usually be the most relevant for practitioners, rather than HIPAA, because it is generally more protective of confidentiality than HIPAA.¹⁹

About this Guide

This guide is organized into two parts. The first part focuses on each type of practitioner likely to be involved in criminal justice-mental health collaborations: behavioral health care, law enforcement, courts, jail and prison, and probation and parole. For each type of practitioner, there is a discussion of whether the involved individuals are considered a “covered entity” under HIPAA or are associated with a “program” regulated by 42 CFR Part 2. There is then a discussion of the circumstances under which an entity can provide PHI and when it can receive it. Each section concludes with several scenario-based frequently asked questions (FAQs) for practitioners. There are additional sections that provide an overview of other types of entities that request or provide information (“business associates” and “qualified service organizations”) and a review of an individual’s right of access to his or her own health information.



The second part of the guide, “Working with Privacy Laws,” provides practical advice on the enforcement of HIPAA and 42 CFR Part 2. The Information-Sharing Tools section then discusses what mechanisms different programs have used to build successful relationships to exchange information. It also includes several program examples of how jurisdictions around the country have managed to share information while maintaining fidelity to the applicable legal framework. The guide concludes with a glossary of terms frequently used in discussing information sharing.

Methodology

The Council of State Governments Justice Center hosted a series of events in the spring and summer of 2009 to elicit the best thinking on criminal justice-mental health information sharing. The National Association of Counties supplemented these events with a survey of its members to identify information-sharing challenges and practices. Program examples culled from the meetings and survey are included in the Information-Sharing Tools section of the guide. The FAQs were drawn from a spring 2009 webinar and were reviewed and refined by an advisory group of subject-matter experts and practitioners.

Notes

1. The need to improve how information is shared in criminal justice-mental health collaborations emerged as a policy recommendation in the Council of State Governments’ 2002 *Criminal Justice/Mental Health Consensus Project Report*. Chapter V’s section on information sharing can be accessed at http://www.consensusproject.org/the_report/ch-V/ps25-sharing-information.

For resources on information sharing in the broader criminal justice context, see the Bureau of Justice Assistance Justice Information Sharing website at <http://www.it.ojp.gov/>.

2. *Health Insurance Portability and Accountability Act* (“HIPAA”), Public Law 104–191, codified at U.S. Code 42 (1996), sec. 261–264 and 1171 *et seq.*

3. For detailed information regarding the HIPAA Security Rule, see <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html>.

4. The North Carolina Healthcare Information and Communications Alliance, Inc., provides an updated discussion of the effective dates for various HITECH Act provisions, which is available at <http://www.nchica.org/HIPAAResources/Samples/BAA%20Packet.pdf>. At this writing, the HHS Office of Civil Rights continues to work on additional proposed regulations. Updates can be found at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/hitechblurb.html>.

5. HIPAA, U.S. Code 42 (1996), sec. 1172(a).

6. For a discussion of the substance abuse regulations, see Legal Action Center, *Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)*, prepared for SAMHSA, June 2010, available at <http://www.samhsa.gov/HealthPrivacy/docs/EHR-FAQs.pdf>.

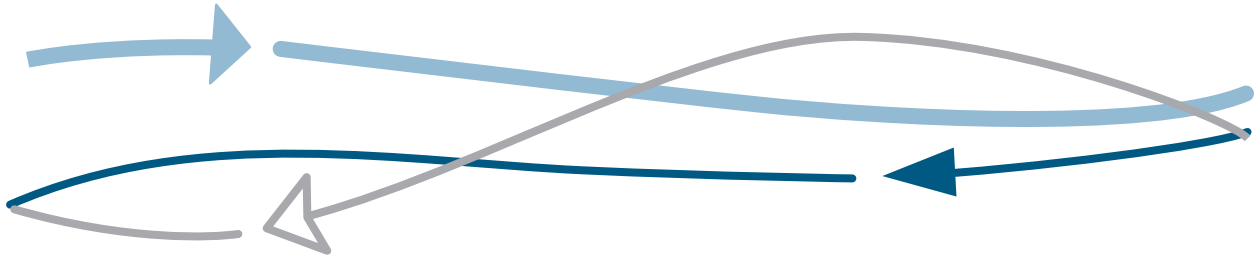
7. *Code of Federal Regulations*, title 42, sec. 2.3(a).



8. 42 CFR, sec. 2.11.
9. 42 CFR, sec. 2.12 (b).
10. 45 CFR, sec. 164.508(a).
11. 45 CFR, sec. 164.506(b).
12. 45 CFR, sec. 164.510.
13. 45 CFR, sec. 164.512.
14. 45 CFR, sec. 164.512(e).
15. 42 CFR 2.1. Subpart (e) carves out permission to share information in two distinct situations: (1) within the Armed Forces and with components of the Department of Veterans Affairs, and (2) when state law requires sharing information because of suspected child abuse or neglect.
16. 45 CFR, sec. 164.502(b)(1).
17. 45 CFR, sec. 164.502(b)(2).
18. For HIPAA, see 42 USC, sec. 1178; for substance use, see 42 CFR, sec. 2.20.
19. The Substance Abuse Mental Health Services Administration guide compares HIPAA and 42 CFR Part 2, available at <http://www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf>.



PART 1: Practitioner Analysis



BEHAVIORAL HEALTH CARE

TREATMENT PROVIDERS HAVE INTERACTIONS with the criminal justice system due to increased use of diversion programs, specialized housing placements in correctional facilities, alternative sanctions, and treatment as a condition of parole or probation, which have all led to the need for health information to be provided to the criminal justice system. Treatment providers familiar with the importance of confidentiality for effective treatment must maintain professional ethics and navigate the federal and state privacy mandates to appropriately share information with criminal justice officials.

Are behavioral health-care providers covered by HIPAA? 42 CFR Part 2?

Behavioral and physical health-care providers, including those based in correctional facilities, are “covered entities” under HIPAA. There is no distinction between general health-care providers, such as hospitals, and specialty mental health providers.

Mental health and substance abuse treatment providers and general health-care professionals are subject to 42 CFR Part 2* when they are working for “programs” that provide substance abuse treatment and are “federally assisted” within the meaning of the regulations.¹

*See the glossary for a discussion of how these terms (in blue type) are defined.



Under what circumstances can behavioral health-care providers disclose protected health information (PHI)?

Covered entities should be familiar with the relevant state law on disclosures, which is likely to apply because it is generally more protective of privacy than HIPAA.

HIPAA may require different levels of permission for sharing **PHI**.^{*} As discussed in the Introduction, covered entities should consider who is asking for the information and the purpose for which the information would be used. For example, a covered entity may use or disclose PHI for its own treatment, payment, and health-care operations.² The regulations spell out the circumstances under which obtaining authorization is not required, which include emergencies where the clinician has reasonably tried to obtain authorization, and, it is worth noting, when the individual is an inmate.³ The U.S. Department of Health and Human Services provides additional guidance on these disclosures.⁴

For substance abuse treatment programs under 42 CFR Part 2, disclosures can occur only with the client's written consent that meets the regulations' requirements for consent forms, with very limited exceptions covered elsewhere in this text.⁵

For various criminal justice-related activities, HIPAA also permits disclosure of PHI without prior client authorization for a range of other purposes where sharing information serves a public benefit, such as to support public health activities; to report potential child abuse or domestic violence to government authorities; to serve victims of abuse, neglect, or domestic violence; for judicial and administrative proceedings; for particular law enforcement purposes; and to follow reporting requirements laid out in other laws.⁶

State law must be consulted to make certain that it is not more restrictive about such disclosures. In general, disclosures are to be limited to only the amount of information needed to accomplish the purpose for which disclosure is made.

Treatment professionals may also wish to consult the other practitioner-specific areas of this guide for additional guidance on the circumstances under which various criminal justice practitioners may request and receive PHI from mental health and substance abuse clinicians.

Under what circumstances can behavioral health-care providers receive PHI?

Health-care providers can receive information from any non-covered entity. As noted above, HIPAA also permits disclosure of PHI for purposes of treatment. Therefore, a health-care provider may request and receive PHI from another covered entity to provide treatment. As noted previously, if state law is more protective of privacy (for example, by requiring an individual's consent before information is shared between

^{*}See pages x and 25 for more information on the different permission types under HIPAA.



covered entities), the state requirements will govern. In contrast to HIPAA, 42 CFR Part 2 provides stricter limits on the disclosure of identifying information to medical personnel who need the information to treat a condition posing an immediate threat to the health of any individual and that requires immediate medical intervention.⁷

FAQs:

Q1. *A client in outpatient treatment threatens a third party, and the clinician believes the client may act on the threat. May steps be taken to protect the third party?*

This question will ordinarily be resolved by state law, and states vary on whether treatment providers are obligated to act. For example, many states permit the treatment provider to exercise discretion in deciding whether to take steps to protect a third party in situations in which the individual at risk is identifiable. In such jurisdictions, the treatment provider will not be liable for breaching confidentiality, but will also not be liable if no action is taken. A smaller number of jurisdictions have created a mandatory duty to warn or protect the third party. It is important to understand the law in the particular state in which the situation arises. HIPAA permits disclosure of information to someone “reasonably able” to prevent or lessen the threat, including the third party, in this circumstance.⁸

Q2. *When a court orders an individual to receive mental health treatment in the community as a condition of community supervision, what information can the probation officer share with the court?*

A supervising officer is not a “covered entity” under HIPAA and is not prohibited from informing the court about diagnosis or treatment. State law again must be consulted to confirm that it does not contain more restrictions than those found in HIPAA. For example, some states may require permission before a supervising officer is allowed to “redisclose” information received from a covered entity, such as a mental health treatment provider.

One approach many local jurisdictions have pursued is to have the court obtain the defendant’s permission for disclosure of health information as a condition of community supervision, or include a provision in the court order that permits the supervising officer to obtain health-related information when necessary to monitor compliance with the conditions of release. This facilitates the exchange of information between the covered entity that is providing treatment and the probation officer. For examples of jurisdictions that have used this approach, see the Information-Sharing Tools section.



There is a special provision in 42 CFR Part 2 for court-ordered drug treatment as a condition of disposition (i.e., as part of a drug court program or other treatment-based alternative to incarceration). Under these circumstances, a treatment “program” may disclose information to criminal justice officials who require it for monitoring and supervision, and the usual rules in 42 CFR Part 2 permitting the client to revoke consent “at will” do not apply.⁹ The 42 CFR Part 2 rules would also apply in the context of a co-occurring treatment plan that is court-ordered.

Q3. *During a treatment session, a participant discloses that she used an illegal drug over the weekend. Can this information be shared with the mental health court team, or do they need to discover it for themselves from a urinalysis test?*

The answer to this question depends on the circumstances that brought the participant to the treatment program. If the court has required disclosure of such information as a condition of the person’s participation in a mental health court (in which case the person likely gave permission by choosing to enter the mental health court), or if the person has permitted release of such information, then it may be shared with the mental health court team. HIPAA does not otherwise permit disclosure to the mental health court team. This is why courts frequently obtain a potential participant’s authorization for disclosures as a condition of their admission to the program.

If applicable, 42 CFR Part 2 would only permit disclosure pursuant to a consent form or court order meeting the regulations’ requirements. As discussed in the previous question, 42 CFR Part 2 specifically addresses disclosures within the criminal justice system for monitoring purposes when participation in a program is a condition of the disposition.¹⁰

Notes

1. *Code of Federal Regulations*, title 42, sec. 2.12 (e)(1).
2. 45 CFR, sec. 164.506(c)(1).
3. 45 CFR, sec. 164.506(a).
4. Available online at <http://www.hhs.gov/hipaafaq/providers/treatment/index.html>.
5. 42 CFR, sec. 2.31.
6. 45 CFR, sec. 164.512.
7. 42 CFR, sec. 2.51.
8. 45 CFR, sec. 164.512(j).
9. 42 CFR, sec. 2.35.
10. 42 CFR, sec. 2.35(a).



LAW ENFORCEMENT

LAW ENFORCEMENT OFFICERS ROUTINELY ENCOUNTER individuals with mental illnesses and health issues that must be considered in determining the proper disposition of a call for service. Health information can help officers assess how to interact with an individual in ways that will produce safer and more positive outcomes, including how to de-escalate a situation effectively and provide a link to services when appropriate. Effective collaborations with treatment providers are contingent on understanding the laws that govern what information can be shared under particular circumstances and the limits on how these providers share health and treatment information. For example, officers need to understand when they can access an individual’s mental health treatment status, so that they can determine if he or she is under a provider’s care and help the individual avoid arrest for a minor offense or preempt a lengthy hold for a mental health evaluation when circumstances warrant.¹

Are law enforcement officials covered by HIPAA? 42 CFR Part 2?

Law enforcement officials are not “covered entities” under HIPAA. They also are not a “federally assisted program” within the meaning of 42 CFR Part 2.

Under what circumstances can law enforcement provide protected health information (PHI)?

Because law enforcement officials are neither covered entities nor federally assisted substance abuse programs, they generally are not bound by either HIPAA or 42 CFR Part 2 when asked to provide PHI to others. For example, when an officer learns about an individual’s mental health condition from a family member or from a person on the scene, HIPAA does not apply. The officer can provide that information to a mental health professional if warranted.

There is an important exception to the general rule: if the officer received the information under a specific provision of HIPAA (for example, the officer received health information through a court order from a covered entity), then “redisclosure” or sharing may be limited (in this example, by a protective order issued by the court). A similar restriction may apply if the officer received the information under a specific provision of state law.

State law will likely govern to whom law enforcement may disclose health information. It will also likely outline access to information held by law enforcement officials, which might include arrest records, computer-aided dispatch records that indicate whether officers previously responded to the individual and mental illness was thought to be a factor in the call for service, or other health information regarding a person taken into custody.



Under what circumstances can law enforcement receive PHI?

HIPAA specifies the circumstances in which PHI can be disclosed for law enforcement purposes.² For example, limited information may be provided without prior authorization to a law enforcement official to identify or locate a fugitive, missing person, suspect, or witness.³ HIPAA specifically defines the types of information that may be disclosed in each of these situations.* Law enforcement working in correctional facilities also should be aware that they may receive PHI of an individual who is under lawful custody for purposes such as providing health care and protecting the health and safety of inmates, law enforcement officers, and employees and officers of jails.⁴

The provisions of 42 CFR Part 2 do not feature similar exceptions for law enforcement. Other than for medical emergencies, or crimes on the premise of a substance abuse program, law enforcement officers will most likely require court orders for obtaining information. An order is generally granted when the disclosure is necessary to protect against an existing threat, to assist the investigation of a serious crime, or to address a variety of litigation needs when the individual is directly involved or the subject of the investigation.⁵

FAQs:

Q1. *Can law enforcement officers responding to an individual in crisis receive PHI from an individual's doctor who is not on the scene?*

HIPAA does not directly address emergency situations when the covered entity is not providing care at the scene. However, HIPAA does permit the disclosure of PHI if the covered entity believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and if the disclosure is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.⁶ This suggests that law enforcement personnel may receive PHI if necessary to address emergencies (e.g., police on the scene with an armed individual threatening suicide may receive information from that individual's treatment provider to use in de-escalating the situation and linking the individual to services).

*(A) Name and address; (B) Date and place of birth; (C) Social security number; (D) ABO blood type and Rh factor; (E) Type of injury; (F) Date and time of treatment; (G) Date and time of death, if applicable; and (H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos. 45 CFR, sec. 164.512(f)(2)(i).

42 CFR Part 2 permits disclosure of information through a court order where “the disclosure is necessary to protect against an existing threat to life or serious bodily injury.”⁷ If state law requires that a disclosure be made, neither HIPAA nor 42 CFR Part 2 prevents it. For example, mandatory child abuse reporting laws in each state are unaffected by HIPAA or 42 CFR Part 2.

Q2. *A police officer appears at a mental health center and asks the center staff whether a person sought for arrest is a patient at the center. Can center staff provide this information?*

HIPAA permits staff to provide limited information, as discussed previously in this section, including “date and time of treatment.” State law, however, may not permit release of even this information, in which case it is the more restrictive state law that governs. This type of disclosure would not be permitted under 42 CFR Part 2.

Q3. *The subject of a call for service discloses that he or she has been diagnosed with a mental illness and/or is taking a specific prescribed medication. Can the officer include the information in a report or to be coded in a dispatch or records system?*

Yes, the officer can disclose information about health status revealed by the suspect, unless prohibited by state law, because the officer is not a covered entity under HIPAA. Similarly, law enforcement can gather health information from non-covered entities, such as callers and on-scene witnesses, and record it in their systems to flag when sending officers to the same location in the future.

Notes

1. For more on the importance of information exchange and confidentiality for law enforcement initiatives involving individuals with mental illnesses, see *Improving Responses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program*, Council of State Governments Justice Center, 2008, p. 7, http://www.consensusproject.org/jc_publications/law-enforcement-elements.
2. *Code of Federal Regulations*, title 45, sec. 164.512(f), (k)(5).
3. 45 CFR, sec. 164.512(f)(2).
4. 45 CFR, sec. 164.512(k)(5).
5. 42 CFR, subpart E.
6. 45 CFR, sec. 164.512(j).
7. 42 CFR, sec. 2.63.



COURTS

COURTS MAY BECOME INVOLVED with the mental health and substance abuse treatment system in a number of ways, including post-booking diversion programs and therapeutic courts. To accomplish the shared goals of treatment success and public safety, these programs require an ongoing exchange of information between court personnel and treatment providers at every stage of the process—from defendants’ initial screening after arrest or arraignment to their acceptance into a specialized problem-solving court or diversion program.¹

Are courts covered by HIPAA? 42 CFR Part 2?

Courts are neither “covered entities” within HIPAA nor “federally assisted programs” within 42 CFR Part 2. However, because of the significant role courts play in directing defendants to treatment and in overseeing compliance with treatment conditions, both HIPAA and 42 CFR Part 2 are relevant to information sharing by and with courts.

Under what circumstances can courts receive protected health information (PHI)?

HIPAA, 42 CFR Part 2, and state law all contain provisions that permit courts to obtain health-care information from covered entities, such as treatment providers, in response to a judicial order. HIPAA integrates the principle of minimum necessity by instructing covered entities to only disclose information to courts that is specifically authorized by the order.² Most state laws will require a judicial order before information can be released to a court. Each of these different sources of law has somewhat different requirements for a court order; states usually detail these requirements under their general statutes governing confidentiality of health-care records and mental health records. Both HIPAA and 42 CFR Part 2 contain specific provisions governing the issuance of a court order.³

Although a judicial order can require the release of PHI, court officials often simply obtain permission from the involved individual. Mental health courts frequently require that a potential participant provide permission to share information between criminal justice and behavioral health-care clinicians as a condition of admission to the program.⁴



FAQs:

Q1. *Does HIPAA require a judge to close proceedings to the public in a mental health court in which PHI regarding the defendant may be disclosed?*

HIPAA does not require hearings in a mental health court to be closed, nor does 42 CFR Part 2 require drug court hearings to be closed. However, some courts have decided to close such hearings, despite the general presumption that criminal proceedings will be opened to the public. Oklahoma is an example of a state where jurisdictions are split on how to handle this.⁵ Although there are no legal requirements that hearings be closed under federal law, many practitioners advise discussing only those aspects of the person's clinical needs or treatment history relevant to the proceeding at hand. Particularly sensitive material germane to the court proceeding can also be discussed at the bench or in chambers as the court and counsel deem appropriate.⁶

Q2. *A mental health professional, working under the auspices of the court, screens an individual for potential eligibility for admission to a mental health court. During screening, the individual reveals details about her prior treatment history. May this information be shared with the members of the mental health court team who decide eligibility for the court if the client has not given permission to share this information? What if the individual also discusses a history of substance abuse?*

HIPAA does not directly address this issue. However, it is reasonable to conclude that in the situation where the mental health professional is doing the screening to determine eligibility for a court program (and not to provide treatment) no consent would be required. At the same time, and regardless of whether it is legally required, obtaining the person's permission for disclosure of information about mental health status or treatment is considered good practice by the field, as is notifying the person before the screening about both the purpose of the screening and the uses of disclosed information.

A similar analysis would apply to the person's disclosure of a history of substance abuse unless the disclosure is provided to staff from a "federally assisted program" covered by 42 CFR Part 2.



Q3. *A criminal court judge, interested in the diversion and early resolution of as many misdemeanor cases as possible, asks the sheriff who administers the jail to notify her each time a person booked into the jail reveals either a history of mental illness or that the person is taking medication for a psychiatric disorder. May the sheriff comply with the judge's request?*

Under most circumstances, a sheriff is not a “covered entity” under HIPAA and so is not bound by its provisions. Under regulatory provisions applicable to correctional facilities, a sheriff responsible for the administration of the jail can receive PHI for various purposes that include management of the facility. Therefore, the sheriff can receive PHI, such as which individuals are on medication, if it is relevant to one of the purposes set forth in the regulation (see the Jails and Prisons section for details). HIPAA does not prohibit redisclosure of PHI by a non-covered entity. Accordingly, if the entire jail has not declared itself a covered entity, a sheriff could redisclose the names of individuals who reveal a history of mental illness and/or medication use at booking. There are two provisos. First, state law may regulate the redisclosure of the type of information discussed here. Second, even if legal authority exists to provide this information without authorization, the jail may decide that obtaining authorization (for example, at booking) for the purposes of determining eligibility for diversion programs makes sense.

Notes

1. For more on information exchanges and confidentiality concerns for court-based initiatives involving individuals with mental illnesses, see *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court*, Council of State Governments Justice Center, 2008, http://www.consensusproject.org/jc_publications/essential-elements-of-a-mental-health-court, and *A Guide to Mental Health Court Design and Implementation*, Council of State Governments Justice Center, 2005, http://consensusproject.org/jc_publications/guide-to-mental-health-court-implementation.
2. *Code of Federal Regulations*, title 45, sec. 164.512(e).
3. For health treatment information, refer to 45 CFR, sec. 164.512(e). For substance use treatment information, see 42 CFR, sec. 2.61–67.
4. The elements of these forms are reviewed in the Information-Sharing Tools section of this guide. For additional discussion of informed consent and information sharing in mental health courts and for examples of forms, see *A Guide to Mental Health Court Design and Implementation*, Council of State Governments, 2005, http://consensusproject.org/jc_publications/guide-to-mental-health-court-implementation.
5. This split is discussed in a 2007 news story: Zina Branstetter, “Some courts closed to public: They include hearings for defendants addicted to drugs or with mental illnesses,” *Tulsa World*, <http://www.allbusiness.com/crime-law-enforcement-corrections/criminal-offenses/12045803-1.html> (accessed April 18, 2010).
6. For a discussion of balancing individual privacy and victims' rights, see *A Guide to the Role of Crime Victims in Mental Health Courts*, Council of State Governments Justice Center, 2008, http://consensusproject.org/jc_publications/guide-to-the-role-of-crime-victims-in-mental-health-courts.

JAILS AND PRISONS

THE INFORMATION-SHARING ISSUES concerning medical and behavioral health that involve correctional staff who must administer a range of services in prisons and jails cause particular confusion. Correctional facilities can be central locations for information collection and sharing: families and community treatment providers may be eager to share health information about those in custody; medical or corrections staff seek to identify individuals with behavioral health issues as quickly as possible and stabilize them; and successful reentry planners require the coordinated transfer of health information from treatment providers in the facility to those in the community. As noted elsewhere throughout this guide, inmates generally have fewer protections for individual information privacy than individuals “outside the walls.”¹

Are correctional institutions covered by HIPAA? 42 CFR Part 2?

HIPAA defines a correctional institution as “any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program” operated by or under contract to federal, state, municipal, or Native American tribal government. The institution must exist for the confinement or rehabilitation of people charged with or convicted of an offense.²

Correctional institutions are generally not “covered entities” under HIPAA unless they declare themselves as such. They are not “health plans” because HIPAA excludes from the definition of “health plan” a government-funded program whose principal purpose is something other than providing or paying for the cost of health care. However, clinical staff who work for a correctional facility meet the definition of “health provider” under HIPAA, whether employed directly by the correctional facility or under contract. If a correctional facility contracts for health-care services, the provider of those services will determine independently whether it is a covered entity (and in most cases will consider itself such). Note that many correctional facilities, as well as state departments of corrections, have defined themselves as covered entities.*

Because [42 CFR Part 2](#) does not contain provisions specifically addressing correctional institutions, the general rules about consent will apply.

*The status of correctional institutions as “covered entities” is not established clearly in the regulations. For a discussion of this debate, see <http://www.nga.org/cda/files/HIPAACorrectionsAJA.PDF>.



Under what circumstances can a correctional facility disclose protected health information (PHI)?

Once a person is discharged from the correctional facility, HIPAA rules apply to the sharing of a person's health information. However, in some circumstances, HIPAA permits sharing information without authorization/consent, although state law may not. For example, if a correctional facility is asked to *provide* health information to another covered entity, such as a psychiatrist, about an individual who has been released from custody, HIPAA does not require the person's permission for the disclosure because it is for the allowable purpose of care, including aftercare. However, state law may require the person's permission in such situations.

The regulations of 42 CFR Part 2 do not permit information to be disclosed to or from correctional officials absent the person's consent.

Under what circumstances can correctional institutions receive PHI?

HIPAA permits **PHI** to be made available to a correctional or other custodial facility for several purposes, including, generally, providing health care and protecting the health and safety of inmates, officers, or other employees of the correctional institution, or persons involved in transporting inmates, or other activities necessary for the maintenance of safety, security, and good order of the institution.³

This provision in HIPAA permits very broad disclosure of PHI without the person's authorization. As always, state law should be consulted to determine whether it is more protective of individual privacy.

Can PHI be released after the individual leaves the correctional institution for community supervision?

"Correctional institutions" covered by HIPAA include some specified types of facilities such as halfway houses. Once an individual leaves these correctional institutions, for example, into probation or parole, the HIPAA disclosure rules or applicable state law would apply.



FAQs:

Q1. *Can a correctional facility access medication information from a pharmacy without a signed release?*

Under HIPAA, PHI may be released without authorization to a correctional facility for several purposes, including treatment. Therefore, absent a more restrictive state law provision, HIPAA permits the release of pharmacy information to a correctional facility.

Q2. *Who determines when disclosing PHI is “for the health and safety” of the individual, other inmates, and others? Must this decision be made by medical personnel?*

HIPAA does not address who makes this determination. Given the broad discretion given to correctional officials under HIPAA, it can be inferred that medical personnel are not the only staff who can make this decision.

Q3. *If the jail treats an inmate for mental illness, can it share this information with the prosecution, defense counsel, and the court?*

If the jail is a covered entity, then HIPAA limits the circumstances when it can disclose PHI. If the person has not signed an authorization permitting information to be shared with the court, then the covered entity has two potential ways to share information with a court: (1) through a court order requesting specific PHI or (2) in response to a judicial subpoena, discovery request, or other process unaccompanied by a court order, if the covered entity receives “satisfactory assurance” of reasonable efforts to notify the individual who is the subject of the PHI.⁴ As discussed in the Courts section, courts, especially mental health or drug courts, often obtain permission to share information from the individual. Note also that state law may be more restrictive than HIPAA on the appropriate response to a non-judicial subpoena. Most, if not all, states do not permit disclosure in response to attorney subpoenas, for example.

Q4. *Can information be shared from within a correctional facility to a parole board making release decisions?*

A parole board does not fall within the exceptions created by HIPAA for disclosures of PHI without the person’s prior authorization. Therefore, if the correctional facility wishes to disclose PHI to a parole board it should be done with the individual’s prior authorization or pursuant to court order.



Q5. *Can information be shared from within a correctional facility to an outside health-care agency or provider when the person is released to provide a continuum of service?*

HIPAA permits the release of information by a covered entity to another treatment provider without the person's authorization for after-care, provided state law allows.

As noted previously, regulations of 42 CFR Part 2 do not permit substance abuse treatment information to be disclosed to or from correctional officials absent the person's consent.

Notes

1. For example, inmates are not entitled to a "privacy notice" that outlines the institution's practices regarding uses of PHI. This is in contrast to the notifications owed most individuals, who must be given adequate notice by covered entities of how they will use PHI. *Code of Federal Regulations*, title 45, sec. 164.520(a).
2. 45 CFR, sec. 164.501.
3. 45 CFR, sec. 164.512(k)(5).
4. 45 CFR, sec. 164.512(e)(1).



COMMUNITY CORRECTIONS (PROBATION AND PAROLE)

COMMUNITY CORRECTIONS CAN BECOME a key link in both monitoring court-ordered treatment, as well as promoting smooth transitions from behavioral health services received behind bars to those in the community. With an increased emphasis on finding alternatives to incarceration for individuals with mental health and substance abuse disorders, **protected health information** (PHI) becomes a part of the work of all community corrections officers, not just those with specialized case loads.¹

Are probation and parole officers covered by HIPAA? 42 CFR Part 2?

Probation and parole officers are not “**covered entities**” under **HIPAA**, nor are they “**federally assisted programs**” within the meaning of that term in **42 CFR Part 2**. However, their access to information may be affected by provisions in each.

Under what circumstances may probation and parole officers provide PHI?

HIPAA and 42 CFR Part 2 do not limit what community correctional officers can disclose. For example, if an individual discloses personal health information to his probation officer, that officer may share or redisclose that information without being affected by HIPAA or 42 CFR Part 2 because the probation officer is not a covered entity or “**program**.” The probation officer may, however, be subject to state law prohibitions on redisclosure.

Under what circumstances can probation and parole officers receive PHI?

The HIPAA provision allowing communication of PHI to a correctional facility no longer applies when an individual “is released on parole, probation, supervised release, or otherwise no longer in lawful custody.”² Federal laws, therefore, limit what information probation and parole officers can *receive* in monitoring compliance with treatment conditions that are part of the person’s supervision. For the supervising officer to receive PHI, the person must have given permission under either the authorization sections of HIPAA or the consent provisions in 42 CFR Part 2. Alternatively, the court can order that the person must waive confidentiality as a condition of probation, or the court can issue an order directing disclosure consistent with the terms of HIPAA³ and/or 42 CFR Part 2⁴ if protected health or substance abuse treatment information is requested.

Also, as noted previously, 42 CFR Part 2 permits disclosure of information to criminal justice officials who require it for monitoring and supervising individuals for whom participation in a substance abuse treatment program is a condition of



disposition (for example, a drug court). The supervised individuals must consent to disclosure, and in this circumstance the individuals' right to revoke consent will be limited to the terms of the agreement—that is, they will not be able to revoke their consent at will.⁵

FAQs:

Q1. *May a mental health treatment provider give PHI to a community corrections officer who requests it to determine whether the person is complying with conditions of probation? Does the answer change if this occurs in a “mental health court”?*

The probation officer must have either a court order or the person's authorization permitting the treatment provider to release the information. The treatment provider should provide what is “minimally necessary” in response to such a request. For example, if the person is required to make weekly visits to the clinic, the fact that the person is or is not making those visits meets that test, but detailed information about the person's mental health status may not. If the person is enrolled in a mental health court, the same advice applies.

Q2. *A probation officer requests information from a provider that meets the definition of a “federally assisted program” under 42 CFR Part 2. The person in treatment has not consented to the release. May the provider release the information?*

The provider may not release the information without the person's written consent on a form that meets the requirements of 42 CFR Part 2.⁶

Notes

1. For an additional policy analysis of the need for information exchange and confidentiality for community corrections initiatives involving individuals with mental illnesses, see *Improving Responses to People with Mental Illnesses: The Essential Elements of Specialized Probation Initiatives*, Council of State Governments Justice Center, 2009, http://www.consensusproject.org/jc_publications/probation-essential-elements.

2. *Code of Federal Regulations*, title 45, sec. 164.512(k)(5)(iii).

3. 45 CFR, sec. 164.512 (e)(1)(i).

4. 42 CFR, sec. 2.1(b)(2)(C).

5. 42 CFR, sec. 2.35.

6. 42 CFR, sec. 2.31 provides a detailed list of the requirements for the consent form, as well as a sample.



BUSINESS ASSOCIATES AND QUALIFIED SERVICE ORGANIZATIONS

ORGANIZATIONS SUCH AS ACCOUNTING FIRMS OR ACCREDITORS may need access to protected health information (PHI) to serve **covered entities** and programs under **42 CFR Part 2**. For example, a law firm providing legal advice to treatment providers may need to know about the providers' clients. Both **HIPAA** and 42 CFR Part 2 set out rules that govern the relationship between these outside organizations and treatment providers and facilitate information sharing without authorizations or court orders.

Under HIPAA, a “business associate” is a person or entity that performs certain activities that involve the use or disclosure of PHI for a covered entity.¹ Business associates perform a variety of functions, including, but not limited to, claims processing, accreditation, quality assurance, and providing legal advice. HIPAA specifies some requirements for “business associate agreements” that create this relationship.² As of the February 2009 signing into law of the Health Information Technology for Economic and Clinical Health (HITECH) Act,* business associates must comply with the privacy provisions of HIPAA to the same extent as covered entities and face the same criminal and civil penalties for non-compliance.³

A similar relationship exists under 42 CFR Part 2, for “qualified service organizations” that provide support functions to federally funded substance abuse treatment programs.⁴ The requirements for a qualified service organization agreement are in the definition provided in the regulations.⁵ Examples of services provided by qualified service organizations include bill collecting, data processing, laboratory analysis, and some types of training. Court orders for information from qualified service organizations must comply with the requirements set out in the regulations.⁶

*HITECH was adopted in February 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

FAQs:

Q1. *A mental health treatment provider decides to employ outside counsel to assist it in addressing privacy questions. The treatment provider wishes to share samples of treatment records with its counsel, drawn from case records of past clients. May the treatment provider do so?*

Before sharing such information, the treatment provider and attorney should enter into a business associate agreement that permits the attorney access without client authorization and provides that the attorney will observe the HIPAA privacy rules and not redisclose the information.

Q2. *A substance abuse program contracts with a therapist to provide group therapy to individuals who, as a condition of probation, were ordered to receive substance abuse and related services. The therapist and substance abuse treatment provider have entered a qualified service organization agreement. The substance abuse provider learns that an employee of the therapist has discussed at social functions information obtained from treatment records. Is the substance abuse treatment provider legally responsible for assuring that the qualified service organization takes steps to remedy this apparent violation?*

In this situation the treatment provider must take steps to ensure that the qualified service organization remedies the problem, including, if necessary, terminating the agreement.

In situations involving business associate agreements under HIPAA, a covered entity is not responsible for assuring that its business associate complies with its regulations. However, if the covered entity is placed on notice that violations have occurred, then the covered entity must take steps to make certain that the violation is remedied and if it is not, to terminate the business associate agreement.

Notes

1. “Business associate” is defined at *Code of Federal Regulations*, title 45, sec. 160.103.
2. 45 CFR, sec. 164.314.
3. Business associates will also have to comply with the HIPAA Security Rule. HHS provides additional guidance for those concerned with the responsibilities of business associates at http://www.hhs.gov/ocr/privacy/hipaa/faq/business_associates/index.html.
4. Qualified Service Organizations is defined at 42 CFR, sec. 2.11.
5. Ibid.
6. 42 CFR, sec. 2.64(e).

INDIVIDUAL RIGHT OF ACCESS TO OWN RECORDS

BOTH HIPAA AND 42 CFR PART 2 provide for extensive access by individuals to their own health-care records.

In general, HIPAA creates a right of access that may be more permissive than a comparable state law.¹ If HIPAA provides this broader right of individual access than the state law, HIPAA would govern.

HIPAA creates two general exceptions of interest regarding individuals' right of access to their own records:²

1. Psychotherapy notes:³ As distinguished from symptoms, diagnoses, and treatment plans, psychotherapy notes are not automatically accessible to an individual and access may be denied, with no right of appeal by the individual. This provision only applies to psychotherapy notes that are maintained separately from the general treatment record.⁴
2. Material compiled in reasonable anticipation of a lawsuit or administrative action: HIPAA limits the individual's right to access notes about his or her care that have been prepared for legal proceedings, rather than for the treatment of the individual. For example, a psychiatrist will be allowed to prepare notes for the purpose of defending him- or herself against a malpractice lawsuit without the concern that these notes will become accessible to the patient.

If access to records has been denied, under most circumstances the individual will have the right to have the denial reviewed.⁵ However, in a limited number of circumstances, the individual has no right to review.⁶ For example, an inmate who has been denied access to his records by a covered entity operating in a correctional setting may not have this decision reviewed if providing this information would endanger the health, safety, rehabilitation, security, or custody of that inmate or other inmates or the safety of corrections personnel.⁷

Under 42 CFR Part 2, individuals may access their substance abuse or alcohol treatment records and inspect and copy them.⁸



FAQ:

Q1. *An individual in treatment on a psychiatric unit of a hospital requests access to his treatment record. The treatment provider is concerned that information given to him in confidence by the individual's probation officer may result in animosity between the individual and his probation officer if disclosed. Can the treatment provider withhold access to information given by the probation officer?*

A treatment provider may deny access to information given in confidence by a third party (other than another treatment provider) if the information was given under an assurance of confidentiality and access might lead to disclosure of the identity of the informant. Denying access on this ground is non-reviewable.⁹

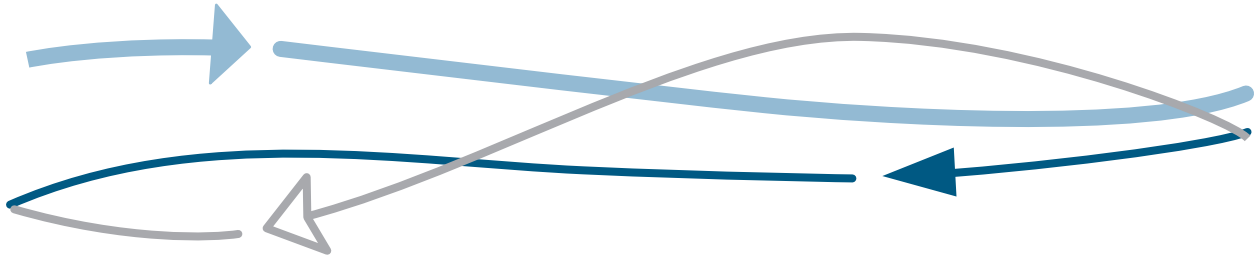
Access may also be denied if a licensed health-care professional determines that the requested access may reasonably endanger the life or physical safety of a third party or lead to substantial harm to a third party or the individual. Denial on this ground is appealable under the processes established by HIPAA.¹⁰

Notes

1. The detailed provisions of an individual's right of access are available in the *Code of Federal Regulations*, title 45, sec. 164.524.
2. 45 CFR, sec. 164.524(a)(1). There is also an exception related to health-care laboratories that can be found at 45 CFR 164.524(a)(1)(iii).
3. 45 CFR, sec. 164.501.
4. For a discussion of patient access to psychotherapy notes, see Donna Vanderpool, "Do Patients Have Access to Therapy or Personal Notes?," *Psychiatric News*, April 18, 2008, vol. 43 no. 8, p. 24, available at <http://www.pn.psychiatryonline.org/content/43/8/24.full>.
5. 45 CFR, sec. 164.524(a)(3).
6. 45 CFR, sec. 164.524(a)(2).
7. 45 CFR, sec. 164.524(a)(2)(ii).
8. 42 CFR, sec. 2.23.
9. 45 CFR, sec. 164.524(a)(2)(v).
10. 45 CFR, sec. 164.524 (a)(3)(i)–(iii).



PART 2: Working with Privacy Laws



PRIVACY LAW PENALTIES

THE OFFICE OF CIVIL RIGHTS IN THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) has primary responsibility for enforcing [HIPAA](#).¹ The [federal rule for enforcing HIPAA](#) is expected to be modified as HHS considers the impact of the Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the Recovery Act of 2009.² For example, now state attorneys general are authorized to enforce HIPAA. Previously, enforcement authority rested exclusively with the federal government. Although an individual cannot bring a lawsuit on his or her own behalf for a violation of HIPAA, an individual whose HIPAA rights were violated may now receive a percentage of any monetary recovery obtained by an enforcement action.

When HIPAA was adopted, it had comparatively modest penalties. However, the Recovery Act increased the potential penalties for violations. For example, the maximum civil penalty was originally \$100 for each violation, with a cap of \$25,000 for multiple violations. This has been increased to up to \$50,000 per violation, with a cap of \$1.5 million per calendar year, for the most severe situations of willful neglect that the organization did not correct. The new law sets out levels of violations based on whether reasonable cause or willful neglect caused the violation and the organization's efforts to correct the error.

An excellent resource with information about enforcement actions, including numbers and types of actions, is maintained by the HHS Office of Civil Rights.³



FAQ:

Q1. *A mental health professional inadvertently releases patient-specific information without the individual's permission. The individual demands an apology and notifies the director of the treatment center that he is going to bring a lawsuit against the treatment center and mental health professional for damages of \$1,000,000. Can the individual really bring this lawsuit?*

There is no private cause of action under HIPAA. This means that an individual cannot bring a lawsuit for a violation. The individual can try to get HHS or the state attorney general to bring the lawsuit.

Even though the individual cannot sue under HIPAA, there may be a state statute that would support a lawsuit based on the release of personal information.

Notes

1. More information on the Office of Civil Rights in the U.S. Department of Health and Human Services and privacy can be found at <http://www.hhs.gov/ocr/office/index.html>.
2. The HIPAA enforcement rule is available at <http://www.cms.gov/Enforcement/Downloads/EnforcementRule.pdf>.
3. The HHS enforcement site is available at <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/>.



INFORMATION-SHARING TOOLS

IT SHOULD BE CLEAR AT THIS POINT that the legal framework governing information sharing should not be seen as an insurmountable obstacle in criminal justice-mental health collaborations. Jurisdictions have developed a variety of approaches to sharing information based on local circumstances, including state law. These approaches include co-locating criminal justice and mental health practitioners, developing procedures to obtain permission forms or court orders, and contracting with business associates and/or qualified services organizations.

Practitioners interested in developing similar processes or documents for their own jurisdictions should consult with counsel familiar with the relevant state and federal laws. The examples and links to documents that follow will provide a starting point for these discussions; however, they are not intended to provide legal advice or substitute for the advice of an attorney.

Uniform Authorization/Consent Form

Obtaining permission from the individual to release his or her health information is a straightforward way to facilitate information sharing. Jurisdictions may obtain an authorization or consent form at various stages of the criminal justice process—such as at booking in a jail or when joining a mental health court or other diversion program.

The forms that jurisdictions use vary in the purposes and parties that they cover. Some jurisdictions provide a checklist for who can be involved with sharing information (e.g., mental health center, probation) and for what purposes.

As discussed in the Introduction, [HIPAA](#) sets out different types of permission—authorization, consent, and notice with opportunity to object.* For authorizations, which are the most common permission necessary, in addition to requiring that the form of the *authorization* contain certain elements, the regulations also require that individuals be put on notice about their right to revoke the authorization, that the writing be in plain language, and that a copy be provided to the individuals.¹

The requirements for written consent under [42 CFR Part 2](#) specify

1. The specific name or general designation of the [program](#) or person permitted to make the disclosure.

*Section 164.508 of the regulations sets out circumstances that require “authorization” and for which “consent” is insufficient, such as sharing protected health information for marketing purposes.



2. The name or title of the individual or the name of the organization to which disclosure is to be made.
3. The name of the patient.
4. The purpose of the disclosure.
5. How much and what kind of information is to be disclosed.
6. The signature of the patient (or that of a guardian for minors, or an authorized person for individuals who are incompetent or deceased).²
7. The date on which the consent is signed.
8. A statement that the consent is subject to revocation at any time except when the program has acted “in reliance on” the consent. For example, if a clinician provided treatment after obtaining consent to disclose the treatment information to the patient’s insurance company, the patient loses the right to revoke his or her consent to sharing the information on this occasion.
9. The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.³

◆ **Riverside County, Calif.**

Individuals participating in the Riverside County Mental Health Court must sign an authorization that allows the mental health staff to release information regarding diagnosis, treatment, compliance, and pre- and/or post-plea status with the public defender’s office, the district attorney, the probation department, and any contracting agencies that may be involved with providing treatment or services. Issues that arise during the operation of the program are addressed in monthly stakeholder meetings of the involved agencies.

◆ **Dutchess County, N.Y.**

Dutchess County has used a variety of tools to facilitate information sharing:

The Dutchess County Assertive Community Treatment (ACT) team has individuals sign an authorization allowing the release of information to treatment providers, such as emergency room staff and physicians providing care. The ACT team also has a letter of agreement with the City of Poughkeepsie Police Department to facilitate information sharing between these entities.*

Mental Hygiene Department staff are co-located in the Dutchess County Jail, the courthouse, and at the probation department to facilitate collaboration. The Mental

*ACT involves multidisciplinary teams, including a psychiatrist, substance use counselors, case managers, nurses, vocational specialists, peer counselors, and others, that provide 24-hour case management services.



Hygiene Department obtains authorizations from individuals at each location that allow exchanges among the involved systems (for example, to provide mental health treatment background that can inform a judge's decision making).

Business Associate Agreements and Qualified Service Organization Agreements

As discussed in the section on Business Associates and Qualified Service Organizations, “covered entities” that meet all requirements may wish to form contractual relationships with other organizations that they work with regularly. Business associates (under HIPAA)⁴ and qualified service organizations (under 42 CFR Part 2)⁵ may receive health information for designated purposes.

Both of these relationships are established through contractual agreements among organizations.

The Office of Civil Rights in the U.S. Department of Health and Human Services (HHS) has provided sample provisions for inclusion in a Business Associate Agreement (BAA) that include guidance on definitions, obligations, and activities of business associates.⁶

◆ **Louisiana Department of Health and Hospitals, the Offices of Addictive Disorders and Mental Health**

The Substance Abuse and Mental Health Services Administration website provides an example from the Louisiana Department of Health and Hospitals of the language and information that should be included in a BAA and Qualified Service Organization agreement.⁷ The agreement specifically “includes joint procedures for screening, assessment, treatment, information management, and evaluation and open sharing of information relevant to the service needs of this population.”

Judicial Orders

As discussed in the Courts section, HIPAA and 42 CFR Part 2 provide for the use of court orders to compel information sharing. HIPAA embraces the principle of minimum necessity by instructing covered entities to only disclose information specifically authorized by the court order. It also provides additional requirements for other court-related documents such as subpoenas and discovery requests.⁸

◆ **Pima County, Ariz.**

The mental health court in Pima County has issued standing court orders explaining (1) the court's interest in arranging appropriate treatment for “mentally ill defendants,” (2) the court's intent to use the information to enhance the defendants' access to care, and (3) the role and functions of the entities that have access to the information. Defendants are also required to consent to the release of mental health information to participate in the mental health court program.



Information-Sharing Systems

At the system level, many jurisdictions employ manual processes or management information systems to routinely bring together criminal justice and behavioral health information.

◆ Pima County, Ariz.

Pima County has developed several processes to cross-check jail intakes with behavioral health records. The jail staff sends the regional behavior health authority a daily list of new inmates and the behavioral health authority identifies inmates who are currently in treatment or who have received services in the past.

At this writing, there is also a process under development to have individuals give permission to pretrial services staff to run arrest information against a behavioral health database, which would indicate people potentially eligible for release to a mental health provider. With this information, pretrial services staff can contact the provider to determine whether the arrestee could be released immediately into treatment.

◆ Illinois Jail Data Link

*The Illinois Jail Data Link allows any Illinois county jail to have access to an interactive Internet database that provides data on detainees that have had a documented mental illness and treatment, whether inpatient or outpatient, with the Division of Mental Health (DMH).**

Individual Illinois counties and their partner mental health agencies engage in a written agreement with DMH and obtain security clearance for access to their documented clients. This information is most recently being used for first-level mental health court eligibility. The data sharing, together with the data collection, has been expanded to more than seven counties across Illinois, including Cook County.

◆ Maryland SMART System

According to the University of Maryland website, “The Statewide Maryland Automated Record Tracking (SMART) system is a web-based tool that provides a client tracking system for state agencies and private treatment providers. Used by treatment providers and drug courts as a management information system, SMART enables collecting substance abuse treatment data, tracking drug court client services, and analyzing program data. SMART is based on the Web Infrastructure for Treatment Services platform.”⁹

*This access was authorized by specific legislation in the state of Illinois: 740 ILCS 110/9.2 permits this secure data exchange for the purposes of continuity of care and linkages to treatment.

◆ **Tarrant County, Tex.**

Individuals entering the Tarrant County jail are cross-checked against the state mental health system database, allowing jail personnel to identify those who have received mental health services in the past.

Other Information-Sharing Programs/Instruments

◆ **Oakland County, Mich.**

The Sheriff's Office Program Services staff provides case management services within the jail and refers individuals to Easter Seals, a service provider under contract with Oakland County Community Mental Health Authority (OCCMHA), which provides psychiatrists, treatment readiness intervention, a case manager, and clerical support for identified individuals. Agreements between the Sheriff's Office and Easter Seals allow information about these individuals to be exchanged. This agreement specifies that the Sheriff's Program Services Unit is the holder of the patient record, whereas Easter Seals/OCCMHA retains ownership of its own documentation within the record folders. Sharing information beyond these two programs requires individuals' release authorizations.

◆ **Dutchess County, N.Y.**

In addition to the use of individual authorizations, Dutchess County uses a contract between the mental hygiene and probation departments to facilitate crisis intervention services. The ACT team has a letter of agreement with the City of Poughkeepsie Police Department to share information that is permitted through individual authorizations. A letter of agreement is also used to facilitate off-hours support to jurisdictions that do not have mental hygiene staff co-located through a HELPLINE program.

◆ **Inmate Medication Information Form¹⁰**

The inmate medication form, developed through a father's collaboration with the Los Angeles Sheriff's Department and the local department of mental health, can be used to provide information on an inmate's mental health and medical needs. Promoted through NAMI, this form is now in use in multiple facilities in California.



Notes

1. *Code of Federal Regulations*, title 45, sec. 164.508(c).
2. As defined in 42 CFR, sec. 2.14 for minors and sec. 2.15 for a patient who is incompetent or deceased.
3. A sample consent form is provided in the regulations at 42 CFR, sec. 2.31(b).
4. 45 CFR, sec. 164.314(a)(2)(i).
5. 42 CFR, sec. 2.11.
6. Information on Business Associate Agreements is available from the Office of Civil Rights in HHS at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html>.
7. The example from the Louisiana Department of Health and Hospitals can be found at http://coce.samhsa.gov/cod_resources/cosig_products/LA%20QSO%20Agreement%20June%202008.pdf.
8. Compare 42 CFR, sec. 164.512(e)(i) with (e)(ii).
9. The University of Maryland Institute for Governmental Service and Research maintains a website about the SMART system, which is available at <http://www.igsr.umd.edu/SMART/about.php> (accessed April 27, 2010).
10. This form is available at <http://www.nami.org/namiland09/convention/CONVINmateMedicationInformationForm.pdf>.



GLOSSARY

42 CFR Part 2 is the part of the *Code of Federal Regulations* under the Public Health chapter that deals with the confidentiality of alcohol and drug use patient records. These regulations apply to all “programs” providing alcohol or substance abuse treatment that are “federally assisted.”

“**Covered entity**” is defined in HIPAA as

1. a health plan;
2. a health-care clearinghouse;
3. a health-care provider who transmits any health information in electronic form in connection with a covered transaction [relating to health claim report, status, payment, etc.].

Mental health treatment providers, either in the community or as a unit in a jail, will ordinarily be covered entities. An organization that is a covered entity is subject to HIPAA’s minimum level of restrictions for sharing protected health information (PHI). A covered entity is subject to HIPAA for all communications, regardless of whether the information is transmitted electronically in a given case.

“**Federally assisted**” is defined in 42 CFR Part 2 as deriving some benefit from the U.S. government, such as accepting Medicaid payments or receiving nonprofit status under the federal tax code.

Under the regulations, programs also are federally assisted if they are conducted by a U.S. department or agency, are being carried out under authorization granted by a U.S. department or agency (such as Medicare providers, authorized methadone maintenance treatments), or are supported by funds provided by any department or agency of the United States (including state or local government units that receive federal funds that could be used for substance abuse treatment). A program is also federally assisted if income tax deductions are granted to those who contribute to the program or if the program itself is tax exempt.¹ Under this definition, a private practitioner providing alcohol or substance abuse treatment will not be a “program” within 42 CFR Part 2 unless the practitioner meets one of the conditions above, for example, through accepting Medicaid reimbursement.

HIPAA refers to the Health Insurance Portability and Accountability Act of 1996, together with regulations promulgated by the U.S. Department of Health and Human Services (HHS), available at 45 CFR Parts 160, 162, and 164. These regulations establish federal standards for the privacy and security of “protected health information” (PHI), including mental health information. HIPAA includes a “Privacy



Rule,” which is the focus of this document, and a “Security Rule,” which deals with the security requirements for information technology systems transmitting health information.

“**Program**” is defined by 42 CFR Part 2 as

1. an individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
2. an identified unit within a general medical facility that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment; or
3. medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers. Examples are provided in the regulations.

For example, this definition means that XY Hospital would not be a program, but the Substance Abuse Unit of XY Hospital would be a program because its primary function is providing substance abuse diagnosis and treatment.

Protected Health Information (PHI), as defined in HIPAA, meets these criteria:

1. It is “health information,” which is information about an individual’s physical or mental health, including the individual’s condition (past, present, future) or provision of health care to that individual.
2. It is “individually identifiable,” meaning that it directly identifies an individual or could be easily used to identify an individual.

The exact regulatory definitions for these HIPAA terms are available at 45 CFR Section 160.103.

For substance abuse information, 42 CFR Part 2.1(a) protects “records of the identity, diagnosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevented function.” In this guide, the term PHI may be used to refer to information protected by either legal authority.

Note

1. *Code of Federal Regulations*, title 42, sec. 2.12 (b).



About the Bureau of Justice Assistance

The Bureau of Justice Assistance (BJA), a component of the U.S. Department of Justice, Office of Justice Programs, supports law enforcement, courts, corrections, treatment, victim services, technology, and prevention initiatives that strengthen the nation's criminal justice system. BJA provides leadership, services and funding to America's communities by:

- Emphasizing local control, based on the needs of the field.
- Developing collaborations and partnerships.
- Providing targeted training and technical assistance.
- Promoting capacity building through planning.
- Streamlining the administration of grants.
- Creating accountability of projects.
- Encouraging innovation.
- Communicating the value of justice efforts to decision makers at every level.

Read more at www.ojp.usdoj.gov/BJA/.

About the Council of State Governments Justice Center

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies—informed by available evidence—to increase public safety and strengthen communities.

Read more at www.justicecenter.csg.org.

About University of South Florida Department of Mental Health Law and Policy

The mission of the Department of Mental Health Law and Policy (MHLP) at the University of South Florida is to promote the health and quality of life of people with mental and substance use disorders by creating, evaluating, disseminating and translating state-of-the-art knowledge to support effective practice across behavioral health and criminal justice systems.

Read more at <http://mhlp.fmhi.usf.edu/web/mhlp/index.cfm>.

