

FERPA-HIPAA Basics: Best Practices For Disclosures of Student Mental Health Records

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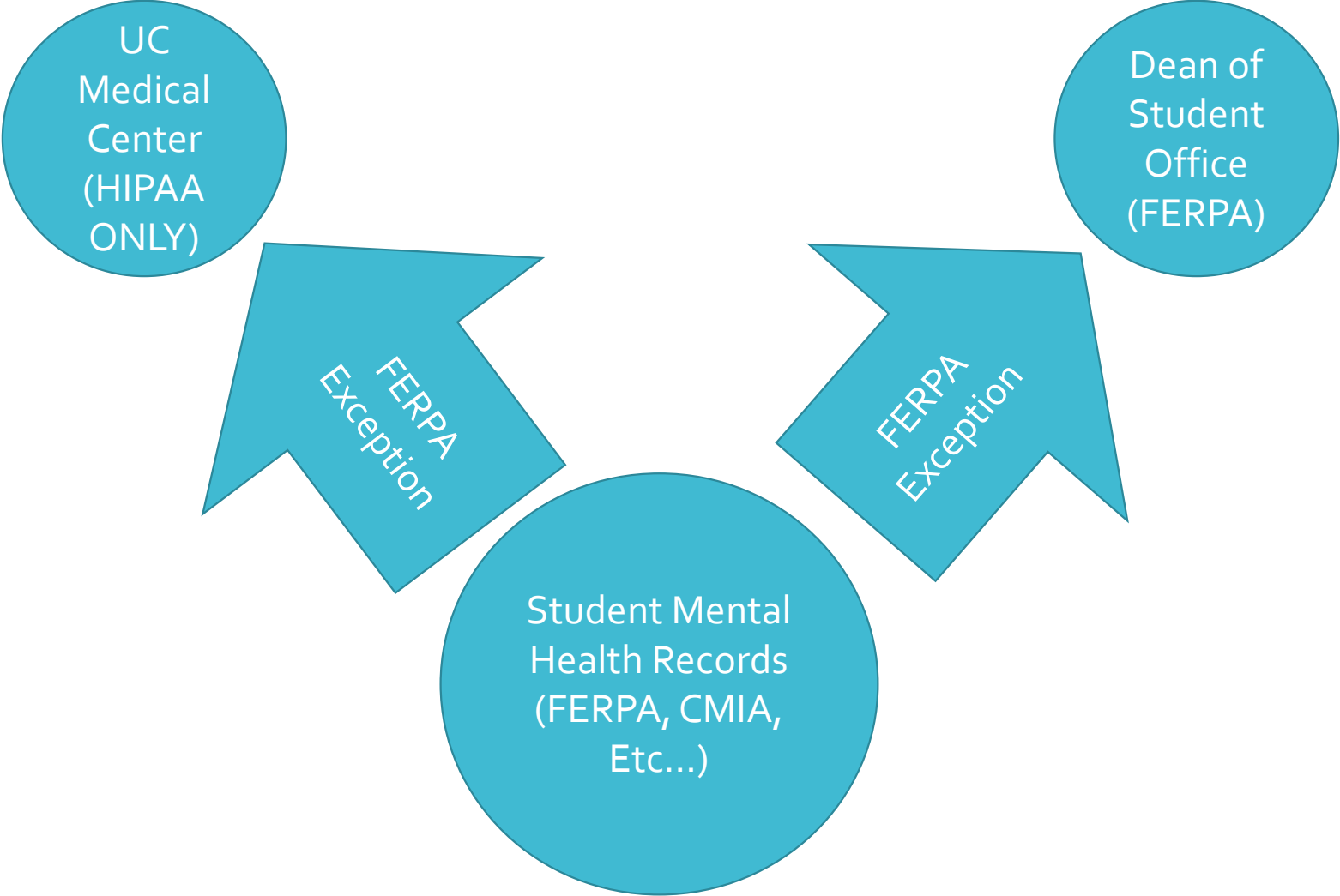
Student Health Records

- **Student** Health Records are covered under FERPA
- **Non-Student** Health Records are covered under HIPAA Privacy Rule
- Student Health and Counseling Center Records covered under FERPA
 - **Students** who are eligible to be seen at SHCS.

Student Mental Health Records

- Why Student Treatment Records are not covered under HIPAA?
 - HIPAA definition of PHI specifically excludes individually identifiable health information in education records covered by and treatment records described in FERPA
 - HIPAA Privacy and Security Rules (relate to PHI) do not apply to these records, even if the records are held by an institution's clinic or other health care provider that is a HIPAA covered entity.
- FERPA
 - Education records do NOT include "treatment records," which are those records that are held by providers in Student Health and Counseling Treatment records
 - But treatment records become education records when made available to anyone other than the student's treating providers (e.g., when disclosed to the student)

Student Mental Health Records



FERPA and University Policy (PACAOS-130)

- Disclosures for educational records under FERPA typically operate differently than with HIPAA.
 - Expectations of health information vs. educational information is different.
- The general belief is that FERPA is more permissive than HIPAA in disclosure of student records, but it depends on the circumstances. There are areas where FERPA is more protective.
 - Public Health disclosures are not permitted without consent (except public health emergency)
 - Education records to an outside provider / consulting physician need consent (depends on treatment)
 - Nonetheless, a minimum necessary standard would apply to sharing information

FERPA and University Policy (PACAOS-130)

- PACAOS-130
 - FERPA only requires that a school official demonstrates a “legitimate educational interest” in the record.
 - Campus and University officials who have been determined to have legitimate educational interest in the records can share records
 - Job Role / Function
 - Determinations as to whether the legitimate educational interest requirement is satisfied shall be made by the head administrator of the unit retaining the information, consistent with campus implementing regulation.
 - Variations in campus-based implementation regulations, practices, reporting structures can impact disclosure determinations

FERPA and University Policy (PACAOS-130)

- While FERPA allows for permissive disclosures of records for valid university functions, there are reasons not to:
 - Differences in professional ethics
 - Privacy concerns
 - Patient-provider relationships
 - Reasons not to disclose should be taken into account by requestor and record holder.
- The Medical Board, Board of Behavioral Health, and Board of Psychology have not opined on disclosure of records in this area. This area of law is very unique.
 - Not everyone is aware of the potential ethical and licensure consequences of releasing mental health records under FERPA.
- University of Oregon Case
 - Case Summary
 - Provider Sanctions
 - Licensure Standards and Ethics

Ten Campuses, Ten Cultures, One UC

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Ten Campuses,
Ten Cultures,
One UC



Considerations at the time of disclosure

- Our best practice is to practice ethically.
- All we do has ethical implications.
- The rights of the client and due process.
- Assessing the implications of disclosing information – Voluntary - when client and counselor have option to disclose. Involuntary when disclosure is legally required.
- Depth of knowledge about FERPA, HIPAA, CMIA, CA Board of Psychology Laws and Regulations, APA Ethical Principles and distinguishing between what is meant by allows/permits and requires/mandates (Must vs May)

Mindset that Produces Inaction

- ❑ Who can I talk to?
- ❑ What can I say?
- ❑ Why can I talk to you but you can't talk to me?



Challenges Faced Nationally by Universities and UC

- ❖ Paralysis and inaction when timeliness and a collaborative stance are paramount.
 - ❖ Convenience versus due diligence – Permissive versus mandatory.
 - ❖ Reacting versus responding to emotional triggers, time pressures, sense of overwhelm, and insufficient knowledge.
 - Behavioral Threat Assessment and Management Teams
 - Communication with Deans of Student Affairs and other University Officials
 - Legal activation
- MIT and Elizabeth Shin
 - Virginia Tech and Seung-Hui Cho
 - University of Oregon and the Counseling Center
 - Regents of UC v. Rosen

Creating “Win-Win” for All

- No need to be a “bull in a china shop”
- Information is power, but shared information and collaboration empowers the system through optimal responses and interventions
- *“Where there is a will, there is a way”* - Gets the job done with optimal risk controls in disclosure continuum



Creating “Win-Win” For All (Cont’d)

- Alignment and coherence versus disarray.
- FERPA does not trump other laws that could apply to particular records. The proposed UC guidelines attest to the flexibility and support within the system for student privacy and confidentiality. We want students to engage in help seeking behaviors.
- Oregon Law now provides confidentiality under State Law to all survivors seeking assistance, especially those on campus.



Proposal for System Wide Guidelines for Disclosure of Student Mental Health Records by Student Health and Counseling Centers- Process

- Garnered the collective intelligence within UCOP and the ten campuses SHS and CAPS – Who needed to sit at the table?
- Consulted with external subject experts for balance and non biased understanding of nuances.
- Ensured that concerns from CC Directors and SHS Directors were heard – roles, functions, oversight, and responsibilities
- Addressed differences between cultures and licensing boards
- Addressed differences between SHS and CAPS Accrediting bodies

Case Vignettes

Vivien Chan, M.D., DFAPA, DFAACAP

Representing Psychiatry

Student A

- Student A is seen as an ongoing patient on the Psychiatry Service
- Student A has a chronic medical, psychiatric condition
- Student A is a graduate student (PhD candidate)
 - If Student A remains adherent to treatment, the symptoms are relatively managed and controlled
 - Student A sees the psychiatrist but procrastinates in obtaining ongoing psychotherapy care (which is delivered in the community)
 - Student A becomes overconfident in treatment and decides to stop taking medication
 - Chaos ensues in Student A's academic life, residence life, laboratory life

Student A

- Student A is hospitalized for increasing symptoms which include bizarre behaviors and statements not based in reality
- Student A has been hospitalized twice before
 - After discharge, Student A is transitioned out of the residence halls because the behaviors displayed while symptomatic violate behavior policies set forth in the prior 2 hospitalizations
 - Student A's roommates are distressed and fearful
 - Some statements and behaviors made while symptomatic lead others to feel unsafe
 - Conduct office gets involved

Student A

- The Consultation Team / Behavioral Intervention Team is notified
 - What, if anything can the treatment providers share?
 - What is important for the treatment providers to know as an outcome of the Consultation Team / Behavioral Intervention Team?
 - If the treatment providers do not routinely attend this meeting, by virtue of being present, this discloses student treatment.
- Student A is found to be in violation of conduct policy
- Student A is advised not to be on campus land due to this violation

Student A

- The treatment services are on campus land
- Abruptly discontinuing services would be a professional ethics problem and considered patient abandonment
 - What obligation, if any, does the Conduct Team have to notify the treating team?
 - How reliable is Student A as a historian to convey complex information?
- On some campuses, an exception is made for treatment services for a period of time judged by the clinician (e.g. 15 – 30 days) to safely make a transition.
 - On some campuses Campus Security stands by to escort students to-and-from their appointments exclusively at the boundaries of campus land

Student A

- How do we decide to inform or not inform students about the Consultation / Behavior Intervention team on a case-by-case basis?
 - On some campuses, it is transparent (when appropriate): “There is a team of people who meet when difficulties arise so that we can coordinate your experience better across campus.”
- What is the distinction between imminent safety and general risk?
- How much does a campus administrator **need to know** in order to do their job while respecting individual privacy?
 - About diagnosis? Symptoms? Behaviors? Whether someone is or isn't in medical care?



Discussion

Student Z

- Student Z is an undergraduate student with many complex psychosocial stressors
 - Student Z has several psychiatric and psychological issues
 - Student Z is active in many student organizations and also is a student worker
- Student Z's psychological symptoms are exacerbated by a social event which eventually includes Title IX / OEOD involvement
- Eventually, a "no contact" order is placed between Student Z and Student F.

Student Z

- Although the OEOD / Conduct Office is notified, other campus units, such as the health center and counseling unit, where both Student Z and Student F can be seen are not notified
- Student Z confides a lot of their problems to Professor W and to Supervisor Y.
- Professor W calls the treating psychiatrist and states, “I know you are seeing Z. I have some concerns.”
 - The treating psychiatrist must not disclose treatment without prior authorization but may receive information.
- Supervisor Y calls the treating psychiatrist and wants to know about possible campus resources in order to help Student Z.
 - In neither case has Student Z pre-signed an authorization of release of health information to Professor W and Supervisor Y.
 - Of course, the treating provider will request authorization from Student Z for Professor W and Supervisor Y. Student Z may or may not decline to authorize release.

Student Z

- Student F also presents to mental health services presenting their concerns about the stressors, but with a different perspective.
 - Student F, if able to be identified in the context of Student Z's life is best not treated by the same provider in order to minimize any perceived or real conflict of interest
- Meanwhile, Student Z's issues also cause discord in their family of origin. Student Z's parents write a letter of complaint to the administrators. Student Z explicitly portrays their parents as toxic and adamantly refuses any authorization of release of health information to parents.

Student Z

- At a medical / psychiatric visit, Student Z discloses thoughts and feelings that require psychiatric hospitalization. Although it is preferred for Student Z to go to the emergency department and to be admitted voluntarily, Student Z wavers about the idea of being hospitalized due to the academic pace and schedule.
 - The physician calls campus police to assess for WIC 5150 involuntary detention criteria
 - Student Z changes their story upon arrival and assessment by campus police in order to lighten the symptoms, impact and severity of presentation
 - Student Z is not found to meet criteria for WIC 5150 by campus police
 - Nothing has changed in the clinical picture in the 2 hours it has taken for the assessment to occur.
 - There is within-University disagreement about the status of Student Z on record by nature of this event and by the knowledge / professional relationship of the involved parties.



Discussion