

# THE MENTAL HEALTH PRIVILEGE IN DIVORCE AND CUSTODY CASES

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# THE MENTAL HEALTH PRIVILEGE IN DIVORCE AND CUSTODY CASES

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## I. Introduction

This paper covers the psychotherapist privilege in litigation, as well as other laws relating to the disclosure of mental health records. The topic is especially relevant to family law practitioners because the mental health of a party can often be an extremely important issue in the case, and the records of that party's mental health treatment may contain the best available information. However, federal law and the laws of every state recognize a psychotherapist privilege that can be asserted by a patient to prevent discovery of these records. Further, specialized federal laws regarding medical records, like HIPAA, govern the process for obtaining these records. This paper will summarize the various interests relating to mental health records, from policies favoring confidentiality to policies favoring release of the records to protect the best interests of a child.

## II. History of the Therapist-Patient Privilege

### A. Purpose of the Privilege

A privilege is an evidentiary doctrine which excludes logically-relevant evidence for policy reasons.<sup>1</sup> A privilege bars the admission of evidence to promote a social policy related to conduct outside the courtroom.<sup>2</sup> In creating a privilege, courts have decided that a policy is important enough to warrant excluding even relevant, reliable evidence.<sup>3</sup> For example, the therapist-patient privilege protects communications between a psychiatrist or psychologist and a patient for the policy of promoting more open, and therefore more meaningful, psychiatric counseling.<sup>4</sup> The United States Supreme Court, in *Jaffee v. Redmond*, analyzed the benefits and costs of the psychotherapist privilege and stated that:

The psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.

In contrast to the significant public and private interests supporting recognition of the privilege, the likely evidentiary benefit that would result from the denial of the privilege is modest. If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without a privilege, much of the desirable evidence to which litigants such as petitioner seek access—for example, admissions against interest by a party—is unlikely to come into being. This unspoken “evidence” will therefore serve no greater truth-seeking function than if it had been spoken and privileged.<sup>5</sup>

Because our understanding of mental health and the importance of communication between a therapist and a patient is relatively recent, this privilege did not historically exist at common law. In some states that recognize the privilege, it is established by statute, and in others, it falls under the umbrella of the constitutional right to privacy.<sup>6</sup> Every state has enacted some statute limiting testimony by doctors, psychiatrists, psychologists, social workers, or other therapists.<sup>7</sup> The statutes vary widely on who is covered by the privilege and the circumstances in which the privilege applies.<sup>8</sup>

### B. Federal Privilege

When the United States Supreme Court submitted its draft of the Federal Rules of Evidence to Congress, the draft included a detailed Article V, which listed many specific privileges familiar to practitioners of state law, including the attorney-client privilege, the therapist-patient privilege, the penitent-clergy privilege,

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<sup>1</sup> EDWARD J. IMWINKELRIED, EVIDENTIARY FOUNDATIONS § 7.01 (7<sup>th</sup> ed. 2008).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> PAUL R. RICE & ROY A. KATRIEL, EVIDENCE: COMMON LAW AND FEDERAL RULES OF EVIDENCE 824 (6<sup>th</sup> ed. 2009).

<sup>5</sup> *Jaffee v. Redmond*, 518 U.S. 1, 11-12 (1996).

<sup>6</sup> See DAVID M. GREENWALD ET AL., TESTIMONIAL PRIVILEGES § 7:1 n.1 (3rd ed. 2005).

<sup>7</sup> *Id.* at § 7:1.

<sup>8</sup> *Id.*

and others.<sup>9</sup> Negative public reaction to the draft prompted Congress to intervene.<sup>10</sup> Delineating clear rules for the privileges was a difficult task for Congress, because so many special interest groups were affected.<sup>11</sup> Ultimately, Congress rejected the idea of specifically enumerating privileges and created the present Federal Rule of Evidence 501, which covers all privileges, and simply states as follows:

#### Rule 501. Privilege in General

The common law—as interpreted by United States courts in the light of reason and experience—governs a claim of privilege unless any of the following provides otherwise: the United States Constitution; a federal statute; or rules prescribed by the Supreme Court.

But in a civil case, state law governs privilege regarding a claim or defense for which state law supplies the rule of decision.<sup>12</sup>

Federal law has a rocky relationship with the physician-patient and therapist-patient privileges. Federal courts have never recognized a physician-patient privilege in cases governed by federal law.<sup>13</sup> Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests.<sup>14</sup> Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.<sup>15</sup> The United States Supreme Court mandated the recognition of a federal therapist-patient privilege in the *Jaffee v. Redmond* case.<sup>16</sup>

Even though the therapist-privilege had not previously existed at common law, the *Jaffee* court held that the Federal Rules of Evidence authorize federal courts to define new privileges by interpreting common law principles in the light of reason and experience.<sup>17</sup> The court observed that the common law is not immutable but flexible, and by its own principles adapts itself to varying conditions.<sup>18</sup> Although declining to delineate the full contours of the therapist-patient privilege, the court broadly described the privilege as protecting confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment.<sup>19</sup> The court held that a privilege protecting confidential communications between a psychotherapist and a patient promotes sufficiently important interests to outweigh the need for probative evidence.<sup>20</sup> Unlike the attorney-client privilege, which shields certain communications from disclosure based on their substance, the psychotherapist privilege is designed to protect the development of the confidential relationship necessary for successful treatment.<sup>21</sup>

In asserting the federal common-law therapist-patient privilege, a party asserting the privilege must establish that (1) confidential communications were made (2) between a licensed psychotherapist and her patient (3) in the course of diagnosis or treatment.<sup>22</sup> As a general rule, the burden rests upon the party claiming a privilege.<sup>23</sup> The psychotherapist privilege extends to licensed psychiatrists and psychologists as well as licensed social workers.<sup>24</sup>

The *Jaffee* court also rejected a balancing test that would breach the confidentiality if a trial judge later determined that the evidentiary need for disclosure outweighed the importance of the patient's interest in privacy.<sup>25</sup> The court stated that if the purpose of the privilege is to be served, the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected.<sup>26</sup> An uncertain privilege, or one which purports to be certain but results in widely varying

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<sup>9</sup> H.R. REP. NO. 93-650 (1975); see also S. REP. NO. 93-1277; H.R. REP. NO. 93-1597.

<sup>10</sup> EDWARD J. IMWINKELRIED, EVIDENTIARY FOUNDATIONS § 7.02 (7<sup>th</sup> ed. 2008).

<sup>11</sup> *Id.*

<sup>12</sup> Fed. R. Evid. 501. The rule as quoted here contains the language effective December 1, 2011. The Committee Notes on Rules—2011 Amendment provides: “The language of Rule 501 has been amended as part of the restyling of the Evidence Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on evidence admissibility.”

<sup>13</sup> See *Gilbreath v. Guadalupe Hosp. Foundation Inc.*, 5 F.3d 785, 791 (5<sup>th</sup> Cir. 1993).

<sup>14</sup> *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

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<sup>17</sup> *Id.* at 8.

<sup>18</sup> *Id.* (citing *Wolfe v. United States*, 291 U. S. 7, 12 (1934), *Funk v. United States*, 290 U. S. 371, 383 (1933), *Hawkins v. United States*, 358 U. S. 74, 79 (1958)).

<sup>19</sup> See *Tesser v. Board of Educ.*, 154 F.Supp.2d 388, 391 (E.D. N.Y. 2001).

<sup>20</sup> *Jaffee v. Redmond*, 518 U.S. 1, 9-10 (1996).

<sup>21</sup> *Tesser v. Board of Educ.*, 154 F.Supp.2d 388, 394 (E.D. N.Y. 2001).

<sup>22</sup> *Id.* at 391.

<sup>23</sup> *Id.*

<sup>24</sup> *Jaffee v. Redmond*, 518 U.S. 1, 15-16 (1996).

<sup>25</sup> *Id.* at 17.

<sup>26</sup> *Id.* at 18.

applications by the courts, is little better than no privilege at all.<sup>27</sup>

### C. The Patient-Litigant Exception

The patient-litigant doctrine is an exception to the physician-patient privilege that provides that if a patient sues, and puts his or her condition at issue in the case, then the patient loses the privilege for communications relevant to that condition.<sup>28</sup> This exception follows the general principle in law against offensive use of privileges--that privileges may not be used as a sword and shield.<sup>29</sup> In deciding whether this exception applies, a judge must examine the complaint and determine whether the complaint tenders an issue of medical condition to which the communication is logically relevant.<sup>30</sup> States differ on the extent that family law cases, such as divorce and custody cases, put a party's mental health at issue and thus waive the therapist-patient privilege.

### D. Other Exceptions

Only confidential communications made to therapists may be privileged.<sup>31</sup> Courts have found that there is no privilege protecting interactions with a therapist where a party does not have an expectation of privacy. Courts have found no privilege in the following circumstances: party knew therapist's evaluations would be submitted to an employer,<sup>32</sup> patient knew that communications would be shared with a third party,<sup>33</sup> counseling is required by employer and reports are submitted to employer,<sup>34</sup> interviews to assess the fitness of police officers,<sup>35</sup> patient reasonably expects communications to be disclosed to a third party.<sup>36</sup> However, courts still have upheld the privilege in some cases where there was no expectation of privacy.<sup>37</sup>

In family law cases, the most common exception to the privilege is for court-ordered evaluations. Obviously, in court-ordered evaluations, there is no expectation of privacy at the outset. Communications between the parties and the court-appointed therapist are not confidential and are not privileged.

### E. The Attorney-Client and Work Product Privileges for Consulting Mental Health Experts

As part of trial preparation, an attorney may consult with, and may have a client consult with, a mental health professional. Ordinarily, a party may not discover facts known or opinions held by an expert who has been retained in anticipation of litigation or to prepare for trial and who is not expected to be called as a witness at trial.<sup>38</sup> Civil rules shield disclosure of these "consulting experts" and their mental impressions under the attorney-client and work-product privileges.<sup>39</sup> The public policy underlying this protection is not to protect a confidential relationship but to promote the adversary system by safeguarding the fruits of an attorney's trial preparations from the discovery attempts of an opponent.<sup>40</sup> Interestingly, voluntary disclosure to a third party by a consulting expert does not necessarily waive this privilege.<sup>41</sup> Compare this to the ethical duty of confidentiality by therapists, where a voluntary disclosure in breach of the duty of confidentiality waives privilege.<sup>42</sup>

This privilege protecting consulting experts is not waived by a party putting his or her medical condition at issue in a case. However, a party cannot prevent discovery of a witness with personal knowledge of relevant facts by attempting to classify him or her as a consulting expert.<sup>43</sup> For example, the opinions of a mental health professional brought into the case specifically to assess the client and provide guidance to the attorney in planning the case would not be discoverable, and the attorney-client and work product privileges would protect communications to that expert. But, attempting to reclassify a mental health professional that has previously treated the client as a consulting expert will not protect the previous knowledge or records

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<sup>27</sup> *Id.*

<sup>28</sup> EDWARD J. IMWINKELRIED, EVIDENTIARY FOUNDATIONS § 7.05[4] (7<sup>th</sup> ed. 2008).

<sup>29</sup> See *Ginsberg v. Fifth Court of Appeals*, 686 S.W.2d 105, 107-08 (Tex. 1985).

<sup>30</sup> EDWARD J. IMWINKELRIED, EVIDENTIARY FOUNDATIONS § 7.05[4] (7<sup>th</sup> ed. 2008).

<sup>31</sup> *Tesser v. Board of Educ.*, 154 F.Supp.2d 388, 392 (E.D. N.Y. 2001).

<sup>32</sup> *Phelps v. Coy*, 194 F.R.D. 606 (S.D.Ohio 2000), *Kamper v. Gray*, 182 F.R.D. 597 (E.D.Mo. 1998).

<sup>33</sup> *Scott v. Edinburg*, 101 F.Supp.2d 1017 (N.D.Ill. 2000).

<sup>34</sup> *Barrett v. Vojtas*, 182 F.R.D. 177 (W.D.Pa. 1998).

<sup>35</sup> *D'Antoni v. Roach*, 1997 WL 627601 (E.D.La. Oct 10, 1997).

<sup>36</sup> *Siegfried v. City of Easton*, 146 F.R.D. 98, 101 (E.D.Pa.1992).

<sup>37</sup> *Williams v. District of Columbia*, 1997 WL 224921 (D.D.C. Apr.25, 1997); *Caver v. City of Trenton*, 192 F.R.D. 154 (D.N.J.2000).

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<sup>38</sup> See F.R.C.P. 26(b)(4)(D).

<sup>39</sup> See, e.g., F.R.C.P. 26(b)(4)(D); Tex. R. Civ. P. 192.3(e); *Shields v. Sturm, Ruger & Co.*, 864 F.2d 379, 382 (5th Cir. 1989).

<sup>40</sup> See *Shields v. Sturm, Ruger & Co.*, 864 F.2d 379, 382 (5th Cir. 1989).

<sup>41</sup> *Id.* (citing *United States v. American Tel. & Tel. Co.*, 642 F.2d 1285, 1299 (D.C.Cir.1980)).

<sup>42</sup> See Section VI(C), below.

<sup>43</sup> *Axelson, Inc. v. McIlhany*, 798 S.W.2d 550, 554 (Tex. 1990) (orig.proceeding).

of that professional under the attorney-client or work product privileges.

### III. No Privilege in Custody Cases

#### A. Statutory Waiver

For family law practitioners, most issues relating to the psychotherapist privilege will appear at the state court level, where the state's privilege statute will govern the outcome. Several states have enacted statutes that expressly contain an exception to the privilege for custody disputes. For example, the Louisiana Code of Evidence provides that there is no privilege:

When the communication relates to the health condition of a patient when the patient is a party to a proceeding for custody or visitation of a child and the condition has a substantial bearing on the fitness of the person claiming custody or visitation, or when the patient is a child who is the subject of a custody or visitation proceeding.<sup>44</sup>

Massachusetts law provides that the privilege does not apply to:

A disclosure in any case involving child custody, adoption, or the dispensing with the need for consent to adoption in which, upon a hearing in chambers, the judge, in the exercise of his or her discretion, determines that the psychotherapist has evidence bearing significantly on the patient's ability to provide suitable care or custody, and that it is more important to the welfare of the child that the communication be disclosed than that the relationship between patient and psychotherapist be protected; provided, however, that in such cases of adoption or the dispensing with the need for consent to adoption, a judge shall first determine that the patient has been informed that such communication would not be privileged.<sup>45</sup>

In states where the statute contains an express exception for custody disputes, the statute will govern the extent of the privilege.

#### B. Common Law Waiver

Kentucky law holds that merely seeking custody of a child automatically waives the psychotherapist privilege. The Kentucky Supreme Court stated, in *Atwood v. Atwood*, "Whenever custody of infants is in dispute, the parties seeking custodial authority subject themselves to extensive and acute investigation of all factors relevant to the permanent and, hopefully, proper award of custody. Of major importance is the mental and physical health of all of the parties and whether the child is in an environment likely to endanger his physical, mental, moral or emotional health."<sup>46</sup> The court went on to hold that the mother had made her mental condition an element to be considered by the court, and that it made no difference that the parties had reached agreement on custody.<sup>47</sup> In Kentucky, because mental health is an immediate issue in custody disputes, an automatic waiver of the psychiatrist-patient privilege results.<sup>48</sup>

In Nebraska, by placing his or her fitness to have custody of a child in issue, a parent waives any physician-patient privilege.<sup>49</sup> However, in view of the personal and confidential communications made between a patient and a psychiatrist, when a litigant seeks custody of a child in a dissolution of marriage proceeding, that action does not result in making relevant the information contained in the file cabinets of every psychiatrist who has ever treated the litigant.<sup>50</sup>

Indiana has possibly the broadest waiver of all. The Indiana Supreme Court held that a mother placed her mental condition in issue when she petitioned for and was granted custody under the original order, and that condition remains in issue for the purposes of custody questions during the children's minority.<sup>51</sup> Further, when a party places a condition in issue by way of a claim, counterclaim, or affirmative defense, she waives the physician-patient privilege as to all matters causally or historically related to that condition, and information which would otherwise be protected from disclosure by the privilege then becomes subject to discovery.<sup>52</sup>

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<sup>46</sup> *Atwood v. Atwood*, 550 S.W.2d 465, 467 (Ky. 1976).

<sup>47</sup> *Id.*

<sup>48</sup> *Bond v. Bond*, 887 S.W.2d 558, 561 (Ky. App. 1994). (citing *Harris v. Commonwealth*, 688 S.W.2d 338, 340 (Ky. App. 1984), cert. denied, 474 U.S. 842, 106 S.Ct. 127, 88 L.Ed.2d 104 (1985)).

<sup>49</sup> *Clark v. Clark*, 220 Neb. 771, 371 N.W.2d 749, 753 (Neb. 1985).

<sup>50</sup> *Id.*

<sup>51</sup> *Owen v. Owen*, 563 N.E.2d 605, 608 (Ind. 1990).

<sup>52</sup> *Id.*

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<sup>44</sup> La. Code Evid. § 510(B)(2)(d).

<sup>45</sup> Mass. G. L. c. 233, § 20B(e).

### C. New York – Past and Present

Early on, New York did not hold that the psychotherapist privilege was automatically waived in custody cases. The 1978 case of *Perry v. Fiumano* addressed the tension between the best interest of the child and the public policy benefits of encouraging parents to seek therapy:

It is not our purpose, however, to discourage troubled parents from seeking professional assistance from the many public and private counseling agencies which are available to aid in relaxing matrimonial tensions and preserving family entities. Nor would we want a custodial parent to forgo needed psychiatric or other help out of fear that confidences will later be unfairly and unnecessarily revealed through the animus act of a present or former spouse. To avoid such potentially chilling effects, it is apparent that these privileges may not cavalierly be ignored or lightly cast aside. There first must be a showing beyond "mere conclusory statements" that resolution of the custody issue requires revelation of the protected material.<sup>53</sup>

The *Hickox* case followed this reasoning and ordered a mother's records produced only to a special master, and not to adverse parties.<sup>54</sup> That court also added that it would be improper to permit disclosure of the records simply for the purpose of enabling the father to prove adultery on the part of the mother.<sup>55</sup>

However, in recent years, New York appears to have gone to the other end of the spectrum. A 2004 case states that "petitioner's mental health was clearly a relevant consideration that had been injected into the proceedings by petitioner. By seeking custody or increased visitation, petitioner had effectively waived his privilege regarding such information."<sup>56</sup> Another case states "privilege has been held to have been waived by a party actively contesting the issue of custody."<sup>57</sup> Even

seeking to maintain custody in a contested proceeding has been held to waive the psychotherapist privilege.<sup>58</sup>

### IV. Court Must Evaluate Privilege in Custody Cases

Some states have held that, even though the best interest of the child is a key concern, it is not necessarily best to encourage broad access to a parent's medical records. In these cases, the courts will balance the value of the therapist-patient relationship against the best interest of the child.

In Missouri, merely seeking custody does not waive privilege.<sup>59</sup> However, the relevant privilege statute prevents a party from invoking the privilege in any custody proceedings involving known or suspected child abuse or neglect.<sup>60</sup> In one case, the court found there was evidence to demonstrate parental misconduct, including the parties' permissiveness regarding the minor children's abuse of alcohol, which strongly suggested parental neglect of the children.<sup>61</sup> The court ordered mother's chemical dependency and outpatient group therapy treatment records to be released.<sup>62</sup>

In Texas, courts have held that the privilege is not absolute in custody cases. In one case, a mother and father were each asking to be appointed sole managing conservator of the children, and mother argued that her medical records were not relevant because they did not contain information regarding her parenting history or abilities.<sup>63</sup> The court found that mother's medical condition relating to her personality and bipolar disorders was relevant to the issue of whether appointing her sole managing conservator was in her children's best interests.<sup>64</sup> The court did not allow all of the mother's medical and mental health records in evidence, but instead took care to exclude references that predated the marriage.<sup>65</sup>

Under Florida law, a party does not make her mental condition "an element of her claim or defense" simply by seeking custody of her children.<sup>66</sup> The court must maintain a proper balance, determining on the one hand the mental health of the parents as this relates to the

<sup>53</sup> *Perry v. Fiumano*, 61 A.D.2d 512, 519 (N.Y. App. Div. 4th Dep't 1978).

<sup>54</sup> *People ex rel Hickox v. Hickox*, 64 A.D.2d 412, 415 (N.Y. App. Div. 1st Dep't 1978).

<sup>55</sup> *Id.*

<sup>56</sup> *Frierson v. Goldston*, 9 A.D.3d 612, 614 (N.Y. App. Div. 3rd Dep't 2004).

<sup>57</sup> *Shepard v. Roll*, 278 A.D.2d 755, 757 (N.Y. App. Div. 3rd Dep't 2000).

<sup>58</sup> *Ace v. State*, 207 A.D.2d 813, 814 (N.Y. App. Div. 2nd Dep't 1994).

<sup>59</sup> *Roth v. Roth*, 793 S.W.2d 590, 592 (Mo.App. 1990).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> *Garza v. Garza*, 217 S.W.3d 538, 555 (Tex.App.--San Antonio 2006, no pet.).

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Roper v. Roper*, 336 So.2d 654, 656 (Fla. 4th DCA 1976).

best interest of the child, and on the other maintaining confidentiality between a treating psychiatrist and his patient.<sup>67</sup> In a child custody dispute, the mental and physical health of the parents is a factor that the court can and should consider in determining the best interests of the child.<sup>68</sup> The mother's mental condition may become an issue; and if so, relevant evidence concerning her mental condition may be presented at trial.<sup>69</sup> The court held that a compulsory pre-trial mental examination would be sufficient to assess the mother's mental condition, and that father was not automatically entitled to the testimony of the mother's treating psychiatrist.<sup>70</sup>

California takes one of the strongest positions in favor of the privilege in custody cases. The physician-patient privilege applies in custody disputes between parents.<sup>71</sup> The relevant privilege statute contains an exception when the patient tenders the condition at issue.<sup>72</sup> The *Koshman* court interpreted this exception to compel disclosure only in cases in which the patient's own action initiates the exposure.<sup>73</sup> The father argued that because the mother was hospitalized for a narcotics overdose, her records were vital for the court to determine whether she was fit to have custody.<sup>74</sup> The court denied the father's request for the mother's records, because, since the mother was not the one tendering her condition at issue, the exception to the privilege did not apply.<sup>75</sup> The *Koshman* case has been cited with approval as recently as 2009.<sup>76</sup>

## V. Privilege in Divorce Cases with no Children

Without the need to act as *parens patriae* to determine the best interests of a child, courts are less willing to breach the psychotherapist privilege. Courts will look at whether a party has truly introduced their mental health as a claim or issue in the case.

Arizona denied a wife access to the husband's psychiatric records in a divorce case where there were no children, and the only issues related to the division of property. The wife argued that the husband "opened the door" and waived privilege by voluntarily disclosing that

he underwent premarital treatment for mental illness.<sup>77</sup> Under Arizona law, a party may waive the privileged status of medical records by the inconsistent conduct of placing the underlying medical condition at issue.<sup>78</sup> The court held that husband had not offered himself as a witness with reference to privileged premarital communications with psychologists or psychiatrists merely by disclosing the fact that he underwent premarital mental treatment.<sup>79</sup> The wife countered that by seeking the court's equitable distribution of the debt for his psychiatric treatment during marriage, he placed his condition at issue.<sup>80</sup> The court did not find that the release of privileged records was necessary to perform an equitable division of the property.<sup>81</sup>

In a Louisiana case, a wife filed suit for separation and contended that she was free from fault.<sup>82</sup> Husband sought her medical records, attempting to prove that she had an abortion after his vasectomy and was therefore guilty of adultery.<sup>83</sup> The court held that claiming she was free from fault did not make her physical condition an essential element of her suit, and no implied waiver of the privilege should be inferred.<sup>84</sup>

## VI. Disclosure of Child's Mental Health Records

An issue that frequently comes up in divorce and custody litigation is whether a parent may obtain access to a child's mental health records. State law varies widely on this subject.

The Texas Supreme Court, in *Abrams v. Jones*, analyzed the issue where a therapist refused to release the records because he believed it would not be in the child's best interest. The court specifically noted that "parents embroiled in a divorce or other suit affecting the parent/child relationship may have motives of their own for seeking the mental health records of the child and may not be acting 'on the patient's [child's] behalf.'"<sup>85</sup> The court analyzed a state statute regarding the release of mental health records to a patient and concluded that a mental health professional is not required to provide access to a child's confidential records if a parent who requests them is not acting "on behalf of" the child.<sup>86</sup> The next question the court addressed was whether a

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<sup>67</sup> *Id.* at 657.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Koshman v. Superior Court*, (1980) 111 Cal.App.3d 294, 297-99 [168 Cal.Rptr. 558].

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Manela v. Superior Court* (2009) 177 Cal.App.4th 1139, 1149 [99 Cal.Rptr.3d 736].

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<sup>77</sup> *Styers v. Superior Ct.*, 161 Ariz. 477, 478-79, 779 P.2d 352 (Ariz.App. 1989).

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* at 480.

<sup>82</sup> *Arsenaux v. Arsenaux*, 428 So.2d 427, 429-30 (La. 1983).

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Abrams v. Jones*, 35 S.W.3d 620, 625 (Tex. 2000).

<sup>86</sup> *Id.*

professional may deny access to a child's records if their release would be harmful to the patient's physical, mental, or emotional health (the language of the relevant statute).<sup>87</sup> At trial, the therapist testified to the following facts: The child initially would not talk to him. He was unable to establish a rapport with her until they discussed confidentiality. The child told the therapist she couldn't talk if there was a chance either parent would know what she said, and the therapist told the child he would not disclose his notes to her parents unless required to do so by a court. The child thereafter opened up to the therapist.<sup>88</sup> The court weighed the parent's rights against the public policy benefits of confidentiality, and held that the parent was not entitled to the therapist's notes. The court stated that "Although a parent's responsibilities with respect to his or her child necessitate access to information about the child, if the absence of confidentiality prevents communications between a therapist and the patient because the patient fears that such communications may be revealed to their detriment, neither the purposes of confidentiality nor the needs of the parent are served."<sup>89</sup>

In contrast, Kentucky provides for an automatic waiver of the child's privilege in custody cases.<sup>90</sup> Illinois law provides for almost unfettered access by a parent to a child's mental health records. The issue was first addressed in the *Dymek v. Nyquist* case.<sup>91</sup> The Illinois statute creating the psychotherapist privilege provided the following exception at the time of the case: "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof: (1) the parent or guardian of a recipient who is under 12 years of age"<sup>92</sup> Even though the parent requesting the records did not have custody of the child at the time of the therapy, the court held she was entitled to receive the results of the child's psychiatric evaluations. The court stated "We think common sense suggests this humane position. Every parent, be he custodial or noncustodial, should be entitled to receive a copy of such a report unless it can be demonstrated a parent has no interest in the health, welfare or well-being of a child."<sup>93</sup> The *Markey* court interpreted the same statute to again hold that the statute means that either mother or father, without

regard to which parent has legal custody, may obtain the records.<sup>94</sup> The court stated:

It is plain that the best interest of the child is served if in the process of determining the best interest of a child in a custody proceeding the trial court assays all of the mental health and developmental disabilities records and communications of the child so that the trial court can be fully apprised of the child's mental health and developmental disabilities. To require the consent of both parents or the custodial parent to waive the privilege of confidentiality frustrates rather than fosters this objective in custody proceedings. It is therefore clearly in the best interest of the child to require only one of the parents to waive the privilege of confidentiality under the statute in custody proceedings.<sup>95</sup>

The *Kerman* case further held that a child's therapist could be forced to testify with the consent of only one of a child's two parents.<sup>96</sup>

## VII. HIPAA and Provider Confidentiality

### A. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>97</sup> was enacted principally to increase the portability and continuity of health insurance and to simplify administrative procedures so as to reduce health care costs.<sup>98</sup> The shift away from paper-based to electronic records was perceived to threaten the confidentiality of sensitive patient information.<sup>99</sup> As a result, HIPAA authorized the United States Department of Health and Human Services (HHS) to promulgate standards governing disclosure of patient health information in the event Congress did not pass privacy legislation within three years of HIPAA's enactment.<sup>100</sup> When Congress did not meet its self-imposed deadline, HHS proposed and subsequently adopted the "Privacy Rule."<sup>101</sup> The Privacy Rule is located at 45 C.F.R. Part 160 and Subparts A and E of

<sup>87</sup> *Abrams v. Jones*, 35 S.W.3d 620, 626 (Tex. 2000).

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Bond v. Bond*, 887 S.W.2d 558, 561 (Ky. App. 1994).

<sup>91</sup> *Dymek v. Nyquist*, 469 N.E.2d 659, 128 Ill. App.3d 859 (Ill.Appl. 1984).

<sup>92</sup> *Id.* (quoting Ill. Rev. Stat. 1983, ch. 91 1/2, par. 804).

<sup>93</sup> *Id.*

<sup>94</sup> *In re Marriage of Markey*, 223 Ill.App.3d 1055, 1059, 166 Ill.Dec. 392, 586 NE2d 350, 352 (1991).

<sup>95</sup> *Id.*

<sup>96</sup> *In re Marriage of Kerman*, 624 N.E.2d 870 (Ill.App. 1993).

<sup>97</sup> Pub L 104-191, 110 U.S. Stat 1936 (1996).

<sup>98</sup> *Arons v. Jutkowitz*, 9 N.Y.3d 393, 411 (N.Y. 2007).

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

Part 164.<sup>102</sup> Health care providers were mandated to begin complying with HIPAA by April 14, 2003.<sup>103</sup>

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.<sup>104</sup> The Privacy Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.<sup>105</sup> Specifically, The Privacy Rule states that a covered entity may not use or disclose protected health information, except pursuant to HIPAA regulations.<sup>106</sup> A "covered entity" is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form.<sup>107</sup> "Protected health information" means specific types of individually identifiable health information.<sup>108</sup> Therefore, when a family law practitioner wants to obtain medical records from a provider, the attorney must comply with required HIPAA procedures to compel a provider to disclose the information.

Under HIPAA regulations, there are two ways for an attorney to compel a provider to disclose protected health information: (1) with a court order;<sup>109</sup> or (2) with a subpoena or discovery request, with notice to the patient or reasonable efforts to secure a protective order.<sup>110</sup> A covered entity may disclose protected health information in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order.<sup>111</sup> Additionally, a covered entity may disclose protected health information in response to a subpoena, discovery request, or other lawful process, without a court order, if the covered entity receives satisfactory assurance that reasonable efforts have been made: (A) to ensure that the individual who is the subject of the protected health information has been given notice

of the request; or (B) to secure a qualified protective order.<sup>112</sup> Further, a covered entity may disclose protected health information if the entity itself makes reasonable efforts to notify the patient or to seek a protective order.<sup>113</sup> "Notice" means a written statement and accompanying documentation demonstrating that (A) the party requesting the information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address); (B) the notice included sufficient information about the litigation to permit the individual to raise an objection; and (C) the time for the individual to raise objections has elapsed, and no objections were filed, or all objections have been resolved and the disclosures being sought are consistent with such resolution.<sup>114</sup> A "qualified protective order" prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation and requires the return or destruction of the protected health information (including all copies made) at the end of the litigation.<sup>115</sup> These regulations were designed to provide a mechanism for an opposing party to obtain records in litigation where a party puts his or her medical condition at issue. HHS has declared that these provisions "are not intended to disrupt current practice whereby an individual who is a party to a proceeding and has put his or her medical condition at issue will not prevail without consenting to the production of his or her protected health information."<sup>116</sup>

State laws requiring disclosure of health information can work even within the HIPAA framework. HIPAA only preempts state law to the extent that the state laws are "contrary" to the Privacy Rule.<sup>117</sup> A state law is contrary to the Privacy Rule only if it would be impossible for a covered entity to comply with both the state requirement and The Privacy Rule, or the former is an obstacle to accomplishing the full purposes and objectives of HIPAA's administrative simplification provisions.<sup>118</sup> Moreover, if a state law mandates a disclosure, the Privacy Rule permits the disclosure under its "required by law" exception, which generally allows a covered entity to disclose protected health information without authorization where disclosure is compelled by another law.<sup>119</sup> HHS has pointedly advised that where "there is a State provision and no comparable or analogous federal provision, or the converse is the case,"

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<sup>102</sup> U.S. Dept. of Health and Human Serv., *The Privacy Rule*, <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html> (last visited Jan. 31, 2012).

<sup>103</sup> 45 C.F.R. § 164.534(a).

<sup>104</sup> U.S. Dept. of Health and Human Serv., *The Privacy Rule*, <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html> (last visited Jan. 31, 2012).

<sup>105</sup> *Id.*

<sup>106</sup> 45 C.F.R. § 164.502(a).

<sup>107</sup> 45 C.F.R. § 160.103.

<sup>108</sup> *Id.* "Individually identifiable health information" is also a defined term, but the concept can be understood, for the purposes of this paper, without quoting the definition.

<sup>109</sup> See 45 C.F.R. § 164.512(e)(1)(i).

<sup>110</sup> See 45 C.F.R. § 164.512(e)(1)(ii).

<sup>111</sup> 45 C.F.R. § 164.512(e)(1)(i).

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<sup>112</sup> 45 C.F.R. § 164.512(e)(1)(ii).

<sup>113</sup> 45 C.F.R. § 164.512(e)(1)(vi).

<sup>114</sup> 45 C.F.R. § 164.512(e)(1)(iii).

<sup>115</sup> 45 C.F.R. § 164.512(e)(1)(v).

<sup>116</sup> *Arons v. Jutkowitz*, 9 N.Y.3d 393, 414 (N.Y. 2007) (quoting 65 Fed Reg 82462, 82530).

<sup>117</sup> 45 C.F.R. 160.203.

<sup>118</sup> *Arons v. Jutkowitz*, 9 N.Y.3d 393, 414 (N.Y. 2007).

<sup>119</sup> *Id.* (referring to 45 C.F.R. 164.512(a)).

there is no possibility of preemption because in the absence of anything to compare “there cannot be ... a ‘contrary’ requirement” and so “the stand-alone requirement—be it State or federal—is effective.”<sup>120</sup>

For example, New York law allows *ex parte* interviews of treating physicians. A party challenged the law as a violation of HIPAA, and the New York court held that there was no conflict:

As a result, there can be no conflict between New York law and HIPAA on the subject of *ex parte* interviews of treating physicians because HIPAA does not address this subject. Accordingly, the Privacy Rule does not prevent this informal discovery from going forward, it merely superimposes procedural prerequisites. As a practical matter, this means that the attorney who wishes to contact an adverse party's treating physician must first obtain a valid HIPAA authorization or a court or administrative order; or must issue a subpoena, discovery request or other lawful process with satisfactory assurances relating to either notification or a qualified protective order.

In the appeals now before us, defendants forwarded to plaintiffs HIPAA-compliant authorizations permitting their treating physicians to discuss the medical condition at issue in the litigation with defense counsel. After plaintiffs declined to sign these authorizations, defendants asked the trial courts for orders compelling them to do so, and the courts granted these requests. This was entirely proper. Plaintiffs waived the physician-patient privilege as to this information when they brought suit, so there was no basis for their refusal to furnish the requested HIPAA-compliant authorizations. The waiver does not depend on the form or medium in which relevant medical information is kept or may be found: information does not fall outside the waiver merely because it is captured in the treating physician's memory rather than on paper (see generally 65 Fed Reg 82462, 82620 [explaining rationale for treating verbal communications the same as paper and electronically based information]). Of

course, it bears repeating that the treating physicians remain entirely free to decide whether or not to cooperate with defense counsel.

HIPAA-compliant authorizations and HIPAA court orders cannot force a health care professional to communicate with anyone; they merely signal compliance with HIPAA and the Privacy Rule as is required before any use or disclosure of protected health information may take place.<sup>121</sup>

## **B. Alcohol and Drug Abuse Patient Records**

Federal law mandates that records relating to the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, shall be confidential and be disclosed only as permitted by the law.<sup>122</sup> The disclosure of records that relate to alcohol or drug abuse treatment is governed by 42 C.F.R. Part 2. A treatment program is defined broadly to include a treatment center, a unit within a general medical facility that provides drug or alcohol treatment, or a person in a general medical care facility whose primary function is providing drug or alcohol treatment.<sup>123</sup> However, not every substance abuse treatment program will be covered by these regulations--the statute and regulations apply only to programs which receive “federal assistance” under the regulations.<sup>124</sup>

The most relevant exception for family law practitioners to these confidentiality requirements is that a court may authorize disclosure of confidential communications if the disclosure is in connection with litigation in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.<sup>125</sup> This incorporates a form of the patient-litigant exception into the protection of drug and alcohol treatment records. The regulations state that a court, in evaluating whether to authorize the disclosure of alcohol or substance abuse treatment records, must weigh

<sup>121</sup> *Arons v. Jutkowitz*, 9 N.Y.3d 393, 415-16 (N.Y. 2007).

<sup>122</sup> 42 U.S.C. § 290dd-2(a).

<sup>123</sup> See 42 C.F.R. § 2.11.

<sup>124</sup> See 42 C.F.R. § 2.12(a)(2); *Beard v. City of Chicago*, No. 03 C 3527 (N.D. Ill. Jan. 7, 2005) (memo op.) (“the statute applies only to those records maintained in connection with the performance of any ‘program or activity’ relating to substance abuse education, prevention, training, treatment, rehabilitation or research, and only if those programs or activities are ‘conducted, regulated or directly or indirectly assisted by any department or agency of the United States.’”).

<sup>125</sup> 42 C.F.R. § 2.63(a)(3).

<sup>120</sup> *Id.* at 415 (citing 64 Fed Reg 59918, 59995).

the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.<sup>126</sup>

The process for obtaining records under these regulations is as follows: A person with a legally-recognized interest in the disclosure of patient records may apply for a court order.<sup>127</sup> The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless: the patient is the applicant, the patient has given a written consent to disclosure, or the court has ordered the record of the proceeding sealed from public scrutiny.<sup>128</sup> The patient and the person holding the records must be given: (1) adequate notice in a manner which will not disclose patient identifying information to other persons; and (2) an opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.<sup>129</sup> Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing.<sup>130</sup> The proceeding may include an examination by the judge of the patient records referred to in the application.<sup>131</sup> An order may be entered only if the court determines that good cause exists.<sup>132</sup> To make this determination the court must find that other ways of obtaining the information are not available or would not be effective, and the public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.<sup>133</sup> The order authorizing disclosure must limit disclosure to the portions of the patient's record which are essential to fulfill the objective of the order; limit disclosure to those persons whose need for information is the basis for the order; and may include other measures, such as sealing the court's record.<sup>134</sup>

In order to force a treatment program to disclose records covered by the regulations, two things are required: (1) an order of a court of competent jurisdiction authorizing the disclosure; and (2) a subpoena compelling

the disclosure.<sup>135</sup> For example, if a rehabilitation program receives a subpoena regarding such records, a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered.<sup>136</sup> Further, if a court order is entered, the program may still refuse to make the disclosure if there is no valid subpoena compelling disclosure.<sup>137</sup>

In an Indiana case, the appellate court found that the trial court did not follow these procedures at all in admitting relevant evidence. However, the court held that the best interests of the child outweighed mother's confidentiality interests under the regulations:

although the trial court did not follow the procedures for disclosure under Title 42, the court's need to serve the interests of the child with regard to the child's relationship to its parents clearly outweighed any confidentiality to which the mother may have been entitled....Accordingly, Mother's rights were not violated under 42 U.S.C.A § 290dd-2(b)(2)(C), as Mother's protected interests in her medical records must give way to the best interests of [the child] in the termination proceeding. We hold that any technical noncompliance with the federal regulations governing the disclosure of these records is harmless.<sup>138</sup>

A Texas court was not willing to go as far as the Indiana court in waiving the requirements of the regulations.<sup>139</sup> The court acknowledged that drug and alcohol records are of considerable importance to the factfinder, but the court was unwilling to ignore the plain language of the statute.<sup>140</sup> The court held that the good cause requirement of the statute is essentially a balancing test, and the court compared the review to the unfair-prejudice-versus-probative-value analysis in determining whether to admit evidence under evidence rule 403.<sup>141</sup>

<sup>126</sup> 42 C.F.R. §§ 2.1(b)(2)(C); 2.2(b)(2)(C).

<sup>127</sup> 42 C.F.R. § 2.64(a).

<sup>128</sup> *Id.*

<sup>129</sup> 42 C.F.R. § 2.64(b).

<sup>130</sup> 42 C.F.R. § 2.64(c).

<sup>131</sup> *Id.*

<sup>132</sup> 42 C.F.R. § 2.64(d).

<sup>133</sup> *Id.*

<sup>134</sup> 42 C.F.R. § 2.64(e).

<sup>135</sup> 42 C.F.R. § 2.61(a).

<sup>136</sup> 42 C.F.R. § 2.61(b)(1).

<sup>137</sup> 42 C.F.R. § 2.61(b)(2).

<sup>138</sup> *Carter v. Knox County Office of Family and Children*, 761 N.E.2d 431, 438-39 (Ind.Ct.App. 2001) (internal citations omitted).

<sup>139</sup> *In re K.C.P.*, 142 S.W.3d 574, 584-85 (Tex.App.--Texarkana 2004, no pet.).

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

### C. Medical Professionals' Duty of Confidentiality

Therapists may have an independent professional duty of confidentiality. For example, the American Psychological Association has issued Ethical Principles and a Code of Conduct that make maintaining confidentiality a "primary obligation."<sup>142</sup> This duty to protect confidentiality even extends to the therapist's recordkeeping, instructing psychologists to "include in written and oral reports and consultations, only information germane to the purpose for which the communication is made."<sup>143</sup>

The Supreme Judicial Court Advisory Committee on Massachusetts Evidence Law has issued an introductory note discussing the differences between confidentiality and privilege:

There is a distinction between a duty of confidentiality and an evidentiary privilege. A duty of confidentiality obligates one, such as a professional, to keep certain information, often about a client or patient, confidential. It also may impose an obligation on a State agency.

A provider's obligation to keep matters confidential may stem from a statute imposing such an obligation (oftentimes with a host of exceptions to that obligation), or may arise as a matter of professional ethics. When a duty of confidentiality is set forth in a statute, there may or may not be an accompanying evidentiary privilege....

In some circumstances, when a provider breaches a duty of confidentiality, the absence of an accompanying evidentiary privilege may permit a party in litigation to gain access to the information or to offer it in evidence.<sup>144</sup>

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<sup>142</sup> American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct, 2010 Amendments*, Standard 4.01, available at: <http://www.apa.org/ethics/code/> (follow "Standard 4: Privacy and Confidentiality" hyperlink) (last visited Jan. 31, 2012).

<sup>143</sup> *Id.* at 4.04(a).

<sup>144</sup> Supreme Judicial Court Advisory Committee on Massachusetts Evidence Law, *Massachusetts Guide to Evidence* (2011 Ed.), Article V Introductory Note, available at <http://www.mass.gov/courts/sjc/guide-to-evidence/articlev-intro.htm> (last visited Jan. 31, 2012) (internal citations and quotations omitted).

Ethical rules are not rules of evidence and do not themselves modify the privilege, but ethical rules embody strong policy interests that courts can consider in applying a privilege.<sup>145</sup> Regarding the similar attorney-client privilege, one court stated that the ethical duty is broader than the evidentiary privilege: "This ethical precept, unlike the evidentiary privilege, exists without regard to the nature or source of information or the fact that others share the knowledge."<sup>146</sup> While privileges protect against the disclosure of confidential communications, they apply only to testimony in legal proceedings.<sup>147</sup> The duty of confidentiality is not limited to judicial settings and applies to matters not covered by privileges, such as nonconfidential communications and secrets that are not communications.<sup>148</sup>

### D. "Duty to Protect" Exception does not Waive Privilege

Most practitioners are familiar with the *Tarasoff* exception to the psychotherapist privilege.<sup>149</sup> In that case, the California Supreme Court held that "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."<sup>150</sup> The obvious rationale behind this rule is that the preservation and protection of the health and safety of innocent third parties outweighs the good achieved by maintaining the confidentiality of life-threatening communications.<sup>151</sup> After that decision, most other states codified the therapist's "duty to protect" third parties from serious threats.<sup>152</sup> This exception, however, merely allows a therapist to warn the third party—it does not overcome the psychotherapist privilege for purposes of litigation. In refusing to incorporate a "dangerous patient" exception to the psychotherapist privilege, the 6<sup>th</sup> Circuit stated that "We see only a marginal connection, if any at all, between a psychotherapist's action in notifying a third party (for his own safety) of a patient's threat to kill or injure him and a court's refusal to permit the therapist to

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<sup>145</sup> See *Henderson v. State*, 962 S.W.2d 544, 555-56 (Tex.Cr.App. 1997).

<sup>146</sup> *Brennan's Inc. v. Brennan's Restaurants, Inc.*, 590 F.2d 168, 172 (5th Cir. 1979) (citing ABA Code of Professional Responsibility, EC 4-4 (1970)).

<sup>147</sup> Deborah Paruch, *The Psychotherapist-Patient Privilege in the Family Court: An Exemplar of Disharmony Between Social Policy Goals, Professional Ethics, and the Current State of the Law*, 29 N. Ill. U. L. Rev. 499 (2009).

<sup>148</sup> *Id.*

<sup>149</sup> *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425, 131 Cal.Rptr. 14, 551 P.2d 334 (Cal. 1976).

<sup>150</sup> *Id.* at 345.

<sup>151</sup> *U.S. v. Hayes*, 227 F.3d 578, 583 (6<sup>th</sup> Cir. 2000).

<sup>152</sup> *Id.*

testify about such threat (in the interest of protecting the psychotherapist/patient relationship) in a later prosecution of the patient for making it.”<sup>153</sup> The court held that “compliance with the professional duty to protect does not imply a duty to testify against a patient in criminal proceedings or in civil proceedings other than directly related to the patient's involuntary hospitalization, and such testimony is privileged and inadmissible if a patient properly asserts the psychotherapist/patient privilege.”<sup>154</sup>

## VIII. Conclusion

Courts and legislatures struggle to weigh the importance of the psychotherapist privilege against other competing values, such as the best interests of a child. Every state legislature has passed laws on the subject, and state and federal courts have overlaid additional common law requirements. These laws create procedures and hurdles to obtaining and introducing mental health evidence. However, if a practitioner follows the required procedures and adequately connects the requested evidence to a claim at issue, particularly one relating to the best interest of a child, then it is likely that the information will be admitted.

## IX. Appendix A – Relevant Statutes

The following list of relevant privilege statutes for each state is taken from DAVID M. GREENWALD ET AL., TESTIMONIAL PRIVILEGES § 7:1 n.2 (3rd ed. 2005):

Alabama: Ala. Code § 34-26-2 (psychologists and psychiatrists); § 34- 8A-21 (licensed professional counselors); § 15-23-42 (victim counselors); Ala. R. Evid. 503A (licensed professional counselors or certified counselor associates, including sexual assault and family violence victim counselors).

Alaska: Alaska Stat .. § 08.86.200 (psychologists and psychological associates); § 08.95.900 (licensed clinical social workers); § 09.25.400 (domestic violence and sexual assault victim counselors); Alaska R Evid 504 (physicians and psychotherapists).

Arizona: Ariz. Rev. Stat. Ann. § 12-2235 (physicians and surgeons); § 32-3283 (behavioral health professionals); § 32-2085 (psychologists); Ariz. R. Evid. 501. .

Arkansas: Ark. Code Ann. § 16-41-101 (Rule 503) (physicians, psychotherapists and chiropractors); § 17-27-311 (licensed counselor, licensed associate counselor, licensed marriage and family therapist, licensed associate marriage and family therapist); Ark. R. Evid. 503 (physician and psychotherapist-patient privilege); §§ 17-103-107, 17-103-108 (social workers); § 17-97-105 (psychologists and psychological examiners).

California: Cal. Evid. Code §§ 990 to 1007 (physicians); §§ 1010 to 1027 (psychotherapists, clinical social workers, school psychologists, marriage, family and child counselors, psychological assistants and interns, associate clinical social workers, trainees, registered psychiatric nurses, and persons rendering mental health treatment or counseling services pursuant to § 6924 of the Family Code); §§ 1035 to 1036.2); (sexual assault victim counselors); §§ 1037 to 1037.8); (domestic violence victim counselors) .

Colorado: Colo. Rev. Stat. § 13-90-107(1)(d) (physician, surgeon, or registered professional' nurse); Colo. Rev. Stat. § 13-90-107(1)(g) (licensed psychologist, professional counselor, marriage and family therapist, social worker, or unlicensed psychotherapist); Colo. Rev. Stat. § 13-90-107(1)(k) (domestic violence and sexual assault victims advocate).

Connecticut: Conn. Gen. Stat. Ann. § 52-146c (psychologists); §§ 52- 146d to -146g (psychiatrists); § 52-146k (battered women's and sexual assault counselors); § 52-146o (physicians, surgeons, and health care providers); § 52-146p (marital and family therapists); § 52-146q (licensed clinical social workers); Conn § 52-146s (professional counselor).

Delaware: Del. Vnif. R. Evid. 503 (physicians and psychotherapists); Del Code Ann tit 24, § 3019 (licensed professional mental health counselors and licensed associate mental health counselors); Del. R. Evid. 503 now applies to mental health providers as well as physicians and psychotherapists. A "mental health provider" is defined by the rule as a

<sup>153</sup> *Id.* at 583-84.

<sup>154</sup> *Id.* at 586.

licensed professional counselor of mental health or licensed associate counselor or a licensed clinical social worker.

District of Columbia: DC Code Ann. § 14-307 (physicians, surgeons and mental health professionals, including psychologists, social workers, marriage, family, and child counselors, rape crisis and sexual abuse counselors, psychiatric nurses and any person reasonably believed to be a mental health professional).

Florida: Fla. Stat. Ann. § 90.503 (psychiatrists, psychologists, clinical social workers, marriage and family therapists, mental health counselors and treatment personnel); § 90.5035 (sexual assault counselors); § 90.5036 (domestic violence advocates).

Georgia: Ga. Code § 24-9-21(5) to (8) (psychiatrists, psychologists, licensed clinical social workers, clinical nurse specialists in psychiatric/ mental health, licensed marriage and family therapists, licensed professional counselors, and communications between such individuals regarding privileged patient communications); §§ 24-9-40 to 24-9-45 (physicians and pharmacists); §§ 24-9-29 (veterinarians); § 26-5-17 (drug abuse treatment facilities); § 43-39-16 (psychologists).

Hawaii: Haw. R. Evid. 504 (physicians); 504. 1 (psychologists); 505.5 (victim counselors).

Idaho: Idaho Code § 9-203(4) (physicians and surgeons); § 9-203(6) (counselors, psychologists, and psychological examiners); § 54-2314 (psychologists); § 54-3213 (licensed social workers); § 54-3410 (licensed counselors); Idaho R. Evid. 503 (physicians and psychotherapists); 516 (school counselors); 517 (licensed counselors); 518 (licensed social workers).

Illinois: 735 Ill. Compo Stat. 5/8-802 (physicians, surgeons, psychologists, nurses, mental health care workers, therapists and health care practitioners); ch 735, § 5/8-802.1 (rape crisis counselors and personnel); ch 735, § 5/8-802.2 (violent crime victim counselors and personnel); ch 750, § 60/227 (domestic violence counselors); ch 225, § 15/5 (clinical psychologists); ch 225, § 20/16 (licensed

clinical social workers and licensed social workers); ch 225, § 55/70 (licensed marriage and family therapists); ch 225, § 107175 (licensed professional counselors and licensed clinical professional counselors); 740 Ill. Compo Stat. §§ 110/1 to 110/17 (all therapists).

Indiana: Ind. Code § 20-1-1.9-6 (school psychologists); Ind. Code. § 20- 6.1-6-15 (school counselors); Ind. Code. § 25-23.6-6-1 (social workers and counselors); Ind. Code § 25-33-1-17 (psychologists); Ind. Code § 34-46-3-1(2) (physicians); Ind. Code § 35-37-6-9 (victim counselors).

Iowa: Iowa Code Ann. § 622.10 (physicians, surgeons, physicians' assistants, advanced registered nurse practitioners, school guidance counselors and mental health professionals, defined to include psychologists registered nurses, social workers, marital and family therapists, mental health counselors and individuals holding at least a master's degree in a related field, and all personnel).

Kansas: Kan. Stat. Ann. § 60-427 (physicians and other practitioners of the "healing arts"); § 74-5323 (licensed psychologists) expand §§ 65-5601 et seq. (treatment facility personnel); § 65-1525 (licensed optometrists); § 65-5810 (registered professional counselors); § 65-6315 (social workers); § 65-6410 (marriage and family therapists).

Kentucky: Ky. R. Evid. 506 (school counselors, sexual assault counselors, professional art therapists, marriage and family therapists, professional counselors, crisis response service providers and victim advocates); 507 (psychotherapists, including psychiatrists, psychologists, licensed clinical social workers and registered nurses practicing psychiatric or mental health nursing).

Louisiana: La. Code Evid. Ann. art 510 (health care providers, including physicians, psychotherapists and their representatives).

Maine: Me. R. Evid. 503 (physicians and psychotherapists); § 4008 (school counselors and school social workers); § 1092-A (dentists); § 7005 (social workers); § 53-A (sexual assault counselors); § 53-B (domestic

- or family violence victim advocates); § 53-C (crime victims and witnesses advocates); § 13862 (counseling professionals, including marriage and family therapists).
- Maryland: Md. Code Ann., Cts. & Jud. Proc. § 9-109 (psychiatrists and psychologists); § 9-109.1 (Supp 1996) (psychiatric-mental health nursing specialists); § 9-121 (social workers).
- Massachusetts: Mass. Gen. Laws Ann. ch. 233 § 20B (psychotherapists); ch 233 § 20J (sexual assault counselors); ch 233 § 20K (domestic violence counselors); ch 112, §§ 135, 135A, 135B (social workers); ch 112, § 129A (psychologists); ch 112, § 172 (mental health and human service professionals) .
- Michigan: Mich. Compo Laws Ann. § 600.2157 (physicians, surgeons and psychiatrists); § 600. 2157a (sexual assault and domestic violence victim counselors); § 333.18237 (psychologists); § 333.16648 (dentists); § 333.18117 (licensed professional counselors); § 333.16911 (marriage and family therapists); § 333.18513 (social workers).
- Minnesota: Minn. Stat. Ann. § 595.02 (physicians, surgeons, dentists, chiropractors, psychologists, consulting psychologists, registered nurses, licensed social workers, chemical dependency counselors and sexual assault counselors).
- Mississippi: Miss. Code Ann. § 13-1-21 (physicians, osteopaths, dentists, hospitals, nurses, pharmacists, podiatrists, optometrists and chiropractors); § 73-31-29 (1995) (psychologists); § 73-30-17 (licensed professional counselors); Miss. R. Evid. 503 (physicians and psychotherapists).
- Missouri: Mo. Ann. Stat. § 491.060(5) (physicians, chiropractors, dentists and psychologists); § 337.055 (psychologists); § 337.540 (counselors); § 337.636 (social workers); § 337.736 (marital and family therapists).
- Montana: Mont. Code Ann. § 26-1-805 (physicians, surgeons and dentists); § 26-1-806 (speech pathologists and audiologists); § 26-1-807 (psychologists); § 26-1-808 (psychology teachers and observers); § 26-1-809 (school counselors, psychologists, nurses and teachers); § 37-22-401 (social workers); § 37-23-301 (professional counselors); Montana § 26-1-812 (victims advocates).
- Nebraska: Neb. Rev. Stat. § 27-504 (physicians, psychologists and professional counselors); § 71-1,335 (mental health practitioners, including professional counselors, marriage and family therapists, certified social workers and certified master social workers).
- Nevada: Nev. Rev. Stat. §§ 49.207 to 49.213 (psychologists); §§ 49.215 to 49.245 (doctors, defined to include physicians, dentists) osteopaths, persons reasonably believed to be any of the foregoing, and psychiatric social workers and their agents); §§ 49.246 to 49.249 (marriage and family therapists); §§ 49.251 to.254 (social workers); § 49.290 (school counselors, psychologists and psychological examiners); § 49.291 (teachers).
- New Hampshire: NH Rev. Stat. Ann. § 329:26 (physicians and surgeons); § 330-A:32 (psychologists, pastoral psychotherapists, clinical social workers, and marriage and family therapists); § 316-A:27 (chiropractors); § 328-C:9 (marital mediators); § 330-C: 12 (alcohol and drug abuse professionals).
- New Jersey: NJ Stat. Ann. §§ 2A:84A-22.1 to 2A:84A-22.7 (physicians); §§ 2A:84A-22.13 to.16 (victim counselors); § 45:8B-29 (marriage and family therapists); § 45:8B-49 (licensed professional counselors and licensed associate counselors); § 45:14B-28 (psychologists and group therapy participants); § 45: 15BB-13 (social workers).
- New Mexico: NM R. Evid. 11-504 (physicians and psychotherapists); 11-509 (probation officers and social service workers in juvenile proceedings); NM Stat. Ann. § 61-9-18 (psychologists and psychological associates); § 61-31-24 (social workers).
- New York: N.Y.C.P.L.R. § 4504 (physicians, dentists, podiatrists, chiropractors and nurses); § 4507 (psychologists); § 4508 (social workers); § 4510 (rape crisis counselors).
- North Carolina: NC St § 8-53 (physicians and surgeons); § 8-53.3 (psychologists,

psychological associates and employees); § 8-53.4 (school counselors); § 8-53.5 (marital and family therapists); § 8-53.7 (social workers); § 8-53.8 (counselors); § 8-53.9 (optometrists); § 8-53.10 (law enforcement employee peer counselors); § 8-53.12 (agents of rape crisis centers and domestic violence programs); § 8-53.13 (nurses).

North Dakota: ND R. Evid. 503 (physicians and psychotherapists); ND Cent Code § 31-01-06.1 (school counselors); §§ 31-01-06.3 to -06.6 (addiction counselors).

Ohio: Ohio Rev. Code Ann. § 2317.02(B) (physicians and dentists); § 2317.02(G) (school guidance counselors, licensed professional clinical counselors, professional counselors, social workers, independent social workers, marriage and family therapists or independent marriage and family therapists, and registered social work assistants); § 4732.19 (psychologists and school psychologists); § 2317.02(J) (chiropractors).

Oklahoma: Okla. Stat. Ann. tit. 12, § 2503 (physicians and psychotherapists); tit. 59, § 1261.6 (social workers); tit. 59, § 1910 (counselors); tit. 59, § 1925.11 (marriage and family therapists); tit. 59, § 1376 (psychologists); tit. 59, § 1939 (licensed behavioral practitioners).

Oregon: Or. Rev. Stat. § 40.230 (psychotherapists); § 40.235 (physicians, licensed or certified naturopaths and chiropractors); § 40.240 (nurses); § 40.245 (school employees and counselors); § 40.250 (clinical social workers); § 40.262 (counselors).

Pennsylvania: 42 Pa. Cons. Stat. Ann. § 5929 (physicians); § 5944 (psychiatrists and psychologists); § 5945 (school personnel, including guidance counselors, school nurses, school psychologists and home and school visitors); § 5945.1 (sexual assault counselors); § 5948 (counselors).

Rhode Island: RI. Gen. Laws. §§ 5-37.3-1 to -4 (physicians, hospitals, intermediate care facilities, health care facilities, dentists, nurses, optometrists, podiatrists, physical therapists, psychiatric social workers, psychologists, any person licensed to provide

health care services, and officers, employees and agents of such providers); § 5-39.1-4 (social workers); § 5-63.2-18 (marriage and family therapists); § 5-69-4 (licensed chemical dependency professionals and licensed chemical dependency clinical supervisors); § 9-17-24 (all health care providers).

South Carolina: SC Code Ann. § 19-11-95 (psychologists, counselors, marital and family therapists, social workers and clinical nurse specialists working in the mental health field); § 44-22-90 (mental health professionals, including general physicians, psychiatrists, psychologists, psychotherapists, nurses, social workers, or other staff members employed in a patient therapist capacity or employees under supervision of them).

South Dakota: SD Codified Laws §§ 19-13-6 to -11 (Rule 503(a)» (physicians and psychotherapists); §§ 19-13-21.1 to -21.2 (school counselors); § 36-26-30 (social workers); § 36-32-27 (licensed professional counselors, counselor associates and employees); § 36-33-29 (marriage and family therapists); § 36-27 A-38 (licensed psychologists).

Tennessee: Tenn. Code Ann. § 24-1-207 (psychiatrists); § 63-7-125 (registered nurses certified and practicing in psychiatric and mental health nursing); § 63-11-213 (psychologists); § 63-22-114 (professional counselors and marriage and family therapists); § 63-23-107 (social workers).

Texas: Tex. R. Evid. 509 (physicians); 510 (mental health professionals and substance abuse counselors); Texas Occupations Code §§ 159.001 to 159.009 (physicians); Texas Occupations Code §.§ 201.401 to 201.405 (chiropractors); Texas Occupations Code §§ 202.401 to 202.407 (podiatrists) .

Utah: Utah Code Ann. § 78-24-8(4) (physicians and surgeons); § 78- 24-8(6) (sexual assault counselors); § 58-41-16 (speech pathologists and audiologists); §§ 58-61-601, 58-61-602 (psychologists); §§ 58-60-113, 58-60- 114 (mental health therapists); Utah R. Evid. 506 (physicians and mental health therapists, including psychologists, clinical or certified

social workers, marriage and family therapists, advanced practice registered nurses designated as registered psychiatric mental health nurse specialists and professional counselors); §§ 58-60-509, 58-60-510 (substance abuse counselors).

counselors, marriage and family therapists, social workers and chemical dependency specialists).

Vermont: Vt. Stat. Ann. tit. 12, § 1612 (physicians, chiropractors, dentists, nurses and mental health professionals, including physicians, psychologists, social workers, mental health counselors, nurses or other qualified persons designated by the commissioner of mental health and mental retardation); § 1614 (domestic violence or sexual assault crisis workers); Vt. R. Evid. 503 (mental health professionals, including physicians, nurses, psychologists, social workers and other persons designated by the commissioner).

Virginia: Va. Code Ann. § 8.01-399 (licensed practitioners of the "healing arts," including clinical psychologists); § 8.01-400.2 (counselors, psychologists and social workers).

Washington: Wash. Rev. Code Ann. § 5.60.060(4) (physicians, surgeons, osteopathic physicians and surgeons, and podiatric physicians and surgeons); § 5.60.060(6) (peer support group counselors); § 5.60.060(7) (sexual assault advocates); §§ 5.62.010 to 5.62.030 (registered nurses); § 18.19.180 (marriage and family therapists, mental health counselors and social workers); § 18.83.110 (psychologists); § 18.53.200 (optometrists).

West Virginia: W. Va. Code § 27-3-1 (information obtained in the course of treatment or evaluation of patients at mental health facilities); § 30-30-12 (social workers); § 30-31-13 (professional counselors).

Wisconsin: Wis. Stat. Ann. § 905.04 (physicians, registered nurses, chiropractors, psychologists, social workers, marriage and family therapists and professional counselors); § 905.045 (domestic violence and sexual assault advocates).

Wyoming: Wyo. Stat. § 1-12-101(a)(i) (physicians); § 1-12-116 (1988) (family violence or sexual assault advocates); § 33-27-123 (psychologists and school psychologists); §§ 33-38-109, 33-38-113 (professional