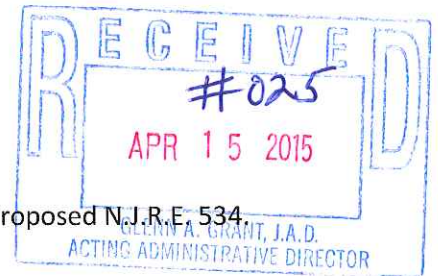

Comment of the New Jersey Mental Health Counseling Association on Proposed N.J.R.E. 534.

To Hon. Judge Grant, Administrative Office of the Courts

Extensive changes to mental health confidentiality privileges have been proposed by the Supreme Court Committee on the Rules of Evidence in proposed N.J.R.E. 534. See, 2015 Report of the Supreme Court Committee on the Rules of Evidence, Part I (Report). The New Jersey Mental Health Counseling Association strenuously objects to the adoption of this Rule in its present form. It is undeniable that there are some disparities in the scope of mental health provider confidentiality privileges, depending on the professional or other status of the providers. However, these disparities pale when compared to the disparity between current mental health provider confidentiality privileges and the substantial restrictions that will be imposed by the proposed New Jersey Rule of Evidence 534. Furthermore

N.J.R.E.534 will create new disparities. One of these disparities is an artifact of superseding federal law. Clients that wish to obtain the upmost privacy protection by hiring private mental health practitioners on a cash basis will find themselves in the anomalous situation in which they will actually have substantially reduced confidentiality protection when compared to all other clients, including clients receiving substance abuse treatment, *see* MacDonald, J. (2015). Analyzing draft rule N.J.R.E. 534: A view from the therapy room. *New Jersey Law Journal,* 219, 605-607 (View from the Therapy Room) (incorporated herein in its entirety, and attached hereto) or inmates in state custody, *see In re Rules Adoption Regarding Inmate-Therapist Confidentiality* (*In re Inmate-Therapist Confidentiality*), 224 *N.J.Super.* 252, 255-56, 540 *A.*2d 212 (App.Div.1988).

It appears that the Committee's initial motivation for considering whether a unified mental health provider privilege was necessary was based on the assumption that the disparities in current law resulted in poor clients treated in community agencies receiving substantially less confidentiality protection than clients that could afford to pay for private practitioners on a self-pay basis or with partial reimbursement from third-party payers. The Committee has provided little if any evidence that this hypothetical harm has actually manifested itself. Indeed, federal mental health and substance use treatment confidentiality protections in place over the past several decades has ensured that virtually all mental health and substance abuse clients receive uniform and near absolute confidentiality protection, with the exception of clients whose practitioners that operate on a cash basis and fall outside of the provisions of HIPAA. See, MacDonald, View from the Therapy Room.

It is evident that the Committee was unable to discern the reasoning behind the limited confidentiality exceptions that currently apply to different provider types. Report at 4 (the current exceptions to the confidentiality privileges may exist by "happenstance or design"). Despite the lack of knowledge of the reasoning, if any, behind the exceptions, the Committee apparently decided to lump together all of the exceptions and apply them across the board merely because these exceptions exist. This seems to be an arbitrary manner in which to greatly reduce the scope of the strong mental health provider privilege and the policy reasons therefor articulated by our Supreme Court in *Kinsella v. Kinsella*, 150 N.J. 276 (1997).

We do not pretend to have an understanding of the genesis of each of the exceptions and why they apply only to one provider-type and not to others, but several possibilities come to mind. The relative weakness of the Social Worker privilege may be explained by the fact the privilege applies to all social workers, including bachelor-level social workers not specifically trained in clinical mental health and the fact that the exceptions preceded the existences of Licensed Clinical Social Workers. The differences in the exceptions to the medical doctor privilege and the near-absolute privileges accorded to licensed professional counselors, LCADCS, and MFTs for instance, might be explained by the fact that medical doctors, aside from psychiatrists, were not traditionally trained to perform psychotherapy while the latter are specifically trained and licensed to conduct psychotherapy.

The disparity in the privilege exceptions to various provider types tend to have been put in place before our Supreme Court articulated the strong policy reasons for having a near-absolute mental health provider privilege, *see Kinsella, supra*, 150 N.J. at 330, described by the Committee as: "(1) to encourage utilization of mental health services, which we refer to as the utilitarian justification; and (2) to protect the patient's privacy, which we refer to as the privacy justification." Report at 5. The Committee fails to describe how its shotgun approach in adopting every confidentiality exception in existing New Jersey law and adding several broad and complicated new ones advances either of these strong public policy interests. While noting that a number of provider organizations supported the adoption of a unified privilege such as The College of New Jersey Department of Counselor Education, which recommended the adoption of a near-absolute privilege along the lined of the current MFT privilege and the National Association of Social Workers-New Jersey, which supported the "highest common denominator in all of the privileges," See Appendix B, Report at 42 the Committee's applied a less-than-the-lowest-common-denominator approach.

The Committee makes certain assumptions about disparate treatment that may be inaccurate. For instance, the committee notes that among other things, persons of lesser means may receive treatment from licensed professional counselors (LPCs) rather than from psychologists, the implication being that LPCs are less qualified to provide treatment, presumably because it requires a PhD to become fully licensed to practice psychology in New Jersey while an LPC license requires a 60 credit master's degree. This presumption fails to take into account the effect of the important differences in experience requirements needed to obtain and maintain these licenses.

A psychologist must have a total of 3500 hours of internship experience over two, only half of which needs to be post-graduation, and does not have to perform any continuing education to maintain the license. The doctoral degree does not need to be in clinical psychology and New Jersey requires that the degree contain 40 credits in six specified areas. An LPC license requires a 60-credit master's degree in clinical mental health counseling with 45 credits in eight out of nine specified areas, 700 hours of post-graduation experience and either 4500 hours of post-graduate experience or 3000. A New Jersey Office of the Attorney General, Application for Licensure/Professional Counselor/Rehabilitation Counselor/Associate Counselor at 2, http://www.njconsumeraffairs.gov/pc/Applications/Application-for-Licensure-Professional-Counselor-Rehabilitation-Counselor-Associate-Counselor.pdf. hours and "30 graduate semester hours beyond the master's degree in areas clearly related to counseling." A Licensed Certified Alcohol and Drug Counselor has similar educational and experience requirements but must have an additional 9 credits in substance abuse courses. Unlike licensed psychologists, LPCs and LCDACs are required to take 40 hours of continuing education biannually in order to renew their license. N.J.A.C.

13:34-15.1. Persons with degrees in substantially related fields are eligible for psychologist, LPC, or LCADC licenses if they can demonstrate equivalency with the core educational requirements.

One of the Committee's justification for a unified privilege is that courts often receive documents that fail to indicate the credential of a mental health provider, requiring the judge to undertake additional steps to determine whether or not a confidentiality privilege exists, Report at 6. It is respectfully submitted that the adoption of a unified privilege will do nothing to alleviate this problem. In the case of a medical doctor, a court would still have to discern whether the doctor was a psychiatrist versus a podiatrist see Report at 7 (confidentiality does not apply to non-behavioral health communications to a podiatrist). To determine whether the privilege applies in the case of a counselor, the court will have to learn whether the counselor was licensed. If the counselor was not licensed, a determination would still have to be made as to whether the counselor was in school – approved internship or was practicing in and exempt facility.

Another justification given is to alleviate disparities in the application of the privilege to persons of differing socioeconomic statuses. Similarly, the Committee notes that under current law "communications of a victim who confers with a psychiatrist or social worker would receive less protection than communications with a victim counselor." The Committee's unusual approach to this removing problem is to by greatly reducing the victim's confidentiality protection, and those of all other types of mental health client, regardless of the credential of the mental health provider. This seems analogous to a court ordering an employer to rectify gender or race employment compensation discrimination simply by reducing the compensation of all parties.

The broad scope, complexity, and unpredictable effect of the numerous exceptions to confidentiality engrafted onto or created in the proposed NJRE 534, will have a devastating effect on the ability of mental health professionals to perform their informed consent obligations and develop client trust that is necessary for successful therapy. See, MacDonald, View from the Therapy Room at . The "Committee appears not to have recognized the global impact of its proposal, stating that "the Committee determined that, consistent with N.J.R.E. 01(a)(2), its draft should apply only to proceedings governed by the Evidence Rule." It is respectfully submitted that, in practice, this is a meaningless distinction, and the impact of the rule can effectively nullify client expectations and entitlement to confidentiality in all settings. "Unlike other rules of evidence, privilege rules extend their effect to the behavior of citizens, and to the arrangements that citizens make, outside the courtroom, in a variety of settings." Paul W. Mosher, M.D., Psychotherapist-Patient Privilege: The History and Significance of The U.S. Supreme Court's Decision in the case of *Jaffee v. Redmond*, in *Confidential Relationships. Psychoanalytic, Ethical, and Legal Contexts.* Koggel, Christine M., Allannah Furlong and Charles Levin (Eds.) Amsterdam/New York, NY, 2003, XVI, 265 pp.

> "[The mental health patient] exposes to the therapist, not only what his words directly express; *he lays bare his entire self, his dreams, his fantasies, his sins, and his shame.* Most persons who undergo a psychotherapy know that this is what will be expected of them, and that *they cannot get help except on that condition. It would be too much to expect them to do so if they knew that all they say and all that the [mental health provider] psychiatrist learns from what they say may be revealed to the whole world from the witness stand."*

In re Inmate-Therapist Confidentiality), 224 *N.J.Super.* 252, 255-56, 540 *A.*2d 212 (App.Div.1988) (quoting *Taylor v. United States,* 222 *F.*2d 398, 401 (D.C. Cir.1955) (italics added)).

The area of mental health providers is highly complex and it will be years or decades before the legal and practical effects of various exceptions contained in N.J.R.E. 534 manifest themselves, particularly provisions like those dealing with explicit or implicit waiver. View from the Therapy Room at . In another, instance, N.J.R.E. 534 creates an exception to confidentiality in civil actions to recover damages resulting from a crime. In contrast, in *In re Inmate-Therapist Confidentiality,* Appellate Division Court ruled that a Department of Corrections regulation that would have required prison therapists to disclose inmates' confidential admissions of past serious crimes, including past murders, improperly infringed on inmates constitutional right to mental health treatment. 224 *N.J.Super.* 252, 263, 540 *A.*2d 212 (App.Div.1988). Do non-inmates have a lesser expectation in the confidentiality of their mental health treatment?

For the reasons set forth herein, the New Jersey Mental Health Counselors Association respectively requests that the Supreme Court reject N.J.R.E. 534 in its present form.

Submitted on behalf of the N.J.M.C.A. Executive Committee, by its member, John A. MacDonald, J.D., M.A., N.C.C. this 10th Day of April, 2015.