Confidentiality: Navigating Roles and Service Provision
Excerpt: Section 4 of the Violence Free Colorado Confidentiality Toolkit- 2019 Update

Foundations of Confidentiality
Confidentiality is critical and protected by law:

- Confidentiality of domestic violence and sexual assault survivor information is governed by Colorado law (CRS § 13-90-107(k) and the Colorado Supreme Court Case People v. Turner, 109 P.3d 639(CO 2005)), and Federal law (VAWA 42 USC §13925/FVPSA 42 USC § 10402, among others). The specific statutory language for Colorado law and federal laws can be found in the Resources Section of this Toolkit.

- Exceptions to confidentiality are informed consent of a survivor, and mandated reporting of known or suspected child abuse or neglect.

- The disclosure of intent to hurt oneself or someone else is not an exception to confidentiality.

- The abuse of elders or at-risk adults is not an exception to confidentiality.

- Consent must be voluntary, informed, written, and reasonably time-limited.

- Mandated reporting obligations are specifically limited and defined by law and include domestic violence and sexual assault advocates (CRS § 19-3-304).

- The identity of the individuals who have sought services at a domestic violence or sexual assault organization is confidential.

- Violations of client confidentiality can create liability for the organization.

WHAT TO KNOW:

- A variety of different roles may be present within community-based DV/SA organizations, and it can be helpful to remember some basic definitions, including privacy, confidentiality, and privilege:
  - “Privacy is a personal choice whether to disclose information,
  - Confidentiality is a responsibility to protect someone else’s choices about disclosure, and
  - Privilege is a legal rule prohibiting the disclosure of private information against someone’s will”.

- “Confidentiality also means than an advocate promises to (a) not intentionally disclose information; (b) take protective measures to prevent inadvertent or unlawful disclosure of information; (c) vigorously challenge any attempts to take the information; and (d) alert the owner of the information about attempts to take it.”

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1 A Primer on Privilege & Confidentiality for Victim Service Providers ©2015 Alicia L. Aiken, J.D., Confidentiality Institute, Inc., & NNEDV
2 A Primer on Privilege & Confidentiality for Victim Service Providers ©2015 Alicia L. Aiken, J.D., Confidentiality Institute, Inc., & NNEDV

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• “Privilege typically means: (a) a court cannot force a survivor or their advocate to disclose information shared between the advocate and survivor, and (b) neither the advocate nor the survivor can be punished for a refusal to disclose the information.”

• Privilege is held by the survivor, not the advocate/privileged professional. A survivor decides what, if any, information the privileged professional would share in or with court. Both the survivor and the advocate/privileged professional are responsible to protect privilege.

• When working to understand different roles within a community-based DV/SA organization, it is considered best practice to identify what role an individual is performing at the organization. For example, if someone is in the role of community-based DV/SA advocate and they also have a mental health license, as long as they are not utilizing their license within the scope of their role as advocate or providing clinical/therapeutic services, then they follow confidentiality and privilege statutes specified for advocates.

• It is also considered best practice to not have dual roles within an organization. Dual or multiple roles may have different exceptions to confidentiality, which can be confusing for both advocates and survivors in understanding what information is protected.

• It is important for all direct services staff within community-based DV/SA organizations to explain their own role, and the exceptions to confidentiality of that role, to survivors. It is also important to explain others’ roles, both inside and outside of the organization that survivors may interact with, and their exceptions to confidentiality. Clarifying differences in roles, and exceptions to confidentiality, can assist survivors in making informed decisions about sharing information.

WHAT TO DO:
• Within community-based DV/SA organizations, survivors may have access to multiple services, including general advocacy (which can also include, but are not limited to, shelter advocacy, non-residential advocacy, housing advocacy, non-attorney legal advocacy, and children/youth advocacy), clinical/therapeutic services, access to an attorney, systems advocacy, and offender treatment victim advocacy.

Community-Based DV/SA Advocates:
• In Colorado, community-based DV/SA advocates are defined and covered by the statute that refers to privileged communications (CRS §13-90-107 (1)(k)). The Colorado Supreme Court case, People v. Turner, further clarified that communications shared by a survivor of domestic violence with a community-based DV advocate, as well as any records of service, are protected.

Clinical/Therapeutic Services:
• Some community-based DV/SA organizations directly employ in-house clinical/therapeutic services, which may include mental health or substance abuse clinicians, and/or trauma therapy specialists (ex. Employees that are licensed or registered unlicensed social workers, professional counselors, or marriage and family therapists). These are mental health credentialed specific services that are separate from general individual or group DV/SA advocacy services.

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3 A Primer on Privilege & Confidentiality for Victim Service Providers ©2015 Alicia L. Aiken, J.D., Confidentiality Institute, Inc., & NNEDV

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In Colorado, clinical/therapeutic staff are also delineated in statute as roles who may not testify without consent (CRS §13-90-107 (1)(g)). While this is in statute, it is important to note that in Colorado, similar to other states, there seems to be a practice of mental health records more frequently being subpoenaed and eventually entered into court record.

In Colorado, as defined in statutes, mental health practitioners must provide a mandatory disclosure of information to all clients, which also includes information to file a grievance with their professional oversight body (CRS §12-245-216, formerly §12-43-214). They are also required to maintain confidentiality, though their exceptions to confidentiality are different than community-based advocates (CRS §12-245-220, formerly §12-43-218).

Exceptions to confidentiality for both community-based DV/SA advocates and clinical/therapeutic staff include informed consent of the survivor, and mandated reporting of known or suspected child abuse or neglect (CRS §19-3-304). However, DV/SA advocates are ONLY mandatory reporters for child abuse or neglect.

Clinical/therapeutic staff have additional exceptions to confidentiality: abuse of at-risk elders, abuse of at-risk adults, suicide, homicide, and school threats. This includes abuse, neglect, and exploitation/mistreatment of an at-risk elder (70 years of age or older) or an at-risk adult (18 years of age or older with intellectual or developmental disability (IDD)). Clinical/therapeutic staff also have a duty to warn, regarding suicidal and homicidal behaviors, and school threats (CRS 13-21-117).

Due to the differences in exceptions to confidentiality, it is considered best practice to maintain separate and protected records access and storage, both physical and electronic. It is also considered best practice to obtain ROIs for any information shared between advocacy staff and clinical/therapeutic staff.

This best practice is informed by the differences in exceptions to confidentiality, as well as being survivor-centered and trauma-informed. Survivors/clients choose who to share information with, through informed consent, understanding what they would like to accomplish by sharing information, and understanding the potential outcomes of sharing information.

Some community-based DV/SA organizations contract with external clinical/therapeutic services. This may include an MOU related to referral and/or billing processes. A contracted clinician/mental health provider creates and maintains their own records. Any information that is shared by a survivor/client requires a release to

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7 2019 HB 19-1172, Recodification of Title 12, Article 245: Mental Health  
§12-245-216. [Formerly §12-43-214] Mandatory disclosure of information to clients (pp. 865-867)  
https://leg.colorado.gov/sites/default/files/2019a_1172_signed.pdf

8 2019 HB 19-1172, Recodification of Title 12, Article 245: Mental Health  
§12-245-220. [Formerly §12-43-218] Disclosure of confidential communications – definitions (pp. 870-873)  
https://leg.colorado.gov/sites/default/files/2019a_1172_signed.pdf

9 Colorado Revised Statutes Title 19 Children’s Code §19-3-304 Persons required to report child abuse or neglect  

CDHS Colorado Adult Protective Services, Division of Aging and Adult Services  
https://www.coloradoaps.com/about-mandatory-reporting.html


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be signed by the survivor/client with both the advocacy staff/organization and the clinician/mental health provider (ex: information related to billing).

**Supervisors of Community-Based Advocates:**

- In Colorado, individuals supervising community-based DV/SA advocates are covered by the statute that refers to privileged communications (CRS §13-90-107 (1)(k)).

- However, it is important to assess a supervisor’s roles if they happen to have a mental health license, and whether they are utilizing their mental health license within the scope of their role as a supervisor. It is also important to assess who they are supervising.

- If a supervisor, whether they have a mental health license or not, is supervising community-based DV/SA advocates, the statutes referring to community-based DV/SA advocates’ privileged communications and confidentiality exceptions, as noted above, are followed.

- If a supervisor is supervising interns, it is important to assess the requirements and expectations of internship practicums regarding whether the supervisor needs to have a mental health license. If having a mental health license is a requirement of supervising (typically Master’s level) interns, then it is considered best practice to follow the statutes and exceptions to confidentiality for that clinical/therapeutic license, for both supervisors and interns.

- In relation to these differing roles, it is also considered best practice for all survivor/client records (physical and electronic) to be maintained and stored separately, and to utilize ROIs for any internal sharing of survivor/client information, when exceptions to confidentiality differ within an organization.

- A supervisor who supervises clinical/therapeutic staff must follow statutes and exceptions to confidentiality for the appropriate clinical/therapeutic licenses.

**Attorneys:**

- Some community-based DV/SA organizations have attorneys on staff. Attorneys are covered by their own statutory mandates and ethical standards, which includes confidentiality. It is considered best practice for all attorney records (physical and electronic) to be maintained and stored separately, and to only be accessible by attorney/legal staff. It is necessary to obtain ROIs for any information to be shared between advocacy staff and internal attorney/legal staff.

- It is considered best practice for DV/SA organizations to have a referral process when referring to attorney/legal services within the same organization. It is also strongly encouraged for attorney/legal program staff to have legal program services available to survivors/clients clearly outlined.

- Some DV/SA organizations that may not have a staff attorney might build community partnerships with attorneys, in order to provide survivors/clients with a list of low cost or pro bono attorneys. It is also necessary to obtain ROIs for any information to be shared between advocacy staff and external attorney/legal staff.

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System-Based Advocacy:
- Sometimes community-based advocates also interact with survivors within systems, which may include court, hospitals, law enforcement, and child protective services. It is important to clarify the role of a community-based DV/SA advocate within these situations and environments.

Things to Consider:
- Is the advocate present for support while the survivor interacts with a system? It is important to explain exceptions to confidentiality, as well as limitations or boundaries of a community-based DV/SA advocate role to survivors/clients.
- It is important for community-based DV/SA advocates to not confirm or deny whether someone is accessing services from a DV/SA organization, even when individuals within systems know the advocate and the organization they work for and may see a survivor/client with the advocate.
- Survivors decide whether or not to share information with individuals within systems that they are accessing. Community-based DV/SA advocates can support survivors/clients by exploring options for information to be shared directly by a survivor/client, or through a voluntary, informed, written, and time-limited ROI. It is considered best practice to explore with survivors/clients the goal of information sharing, as well as any potential risks or unintended consequences that may result from releasing information.
- If community-based DV/SA advocates respond to voluntary survivor call-outs (for example, if contacted by law enforcement or a hospital), a survivor’s/client’s confidentiality is maintained by the advocate unless a ROI is signed, even if system-based individuals (for example, law enforcement officers or hospital staff) request follow-up information.
- Community-based DV/SA advocates who participate on community-task forces may not share any survivor/client information, including confirming or denying an individual is receiving services from a DV/SA organization. Specific survivor/client information may not be shared without a ROI, but general knowledge about DV/SA can be shared.

Offender Treatment Victim Advocacy:
- Some community-based DV/SA organizations also provide offender treatment victim advocacy services. A Treatment Victim Advocate (TVA) is an advocate who provides support specifically to survivors of domestic violence, whose offenders are attending court-ordered domestic violence offender treatment. Some community-based advocacy organizations create a MOU with offender treatment providers to provide this service.

Things to Consider:
- Treatment Victim Advocates (TVAs) have different exceptions to confidentiality than community-based DV/SA advocates, and do not currently exist in any CO statutes (See Colorado Domestic Violence Offender Management Board (DVOMB) Standards for Treatment with Court Ordered Domestic Violence Offenders, Section 7.0). TVAs also do not have any statutory protection regarding subpoena of records.
- Per the DVOMB Standards, TVAs must maintain survivor/client confidentiality, but their exceptions to confidentiality include known or suspicion of child abuse or neglect, as well as abuse of at-risk elders.
TVAs may have varied backgrounds, including mental health licensure. Section 7.0 of the DVOMB Treatment Standards cites that TVAs will also comply with any statutes, rules and policies of their governing mental health board. TVAs are also encouraged to maintain records of confidential victim information only as long as is necessary to meet a survivor’s needs.

It is considered best practice for any community-based DV/SA advocate doing TVA work to maintain separate roles, in order to not have overlap with any survivors/clients that may access a DV/SA organization separately from any TVA support, which includes, but is not limited to, general DV/SA advocacy as well as clinical/therapeutic services.

Due to the differences in exceptions to confidentiality, it is considered best practice to maintain separate and protected records access and storage (both physical and electronic). It is also necessary to obtain ROIs for any information shared between community-based advocacy staff and TVA staff.

Questions To Consider Overall:
- What is the individual’s role within the DV/SA organization?
- What are the exceptions to confidentiality in this role?
- Have exceptions to confidentiality been explained to survivors/clients?
- Are there any dual or multiple roles occurring for an individual staff member?
- Who has access to survivor/client information?
- How are documents stored (physically and electronically), and who has access to these?
- What is the purpose of sharing survivor/client information within an organization?
- What goal is the survivor/client trying to achieve through information sharing?
- Is the survivor/client able to choose via voluntary, informed consent about sharing information?

SUMMARY:
Navigating roles and service provision within community-based DV/SA advocacy organizations can be complicated at times. It is imperative for all staff members, volunteers, interns, and Board members of community-based DV/SA to understand the concepts of and Colorado statutes that pertain to privacy, confidentiality, and privilege. Many questions that arise about confidentiality can be answered through exploring an individual’s role within a community-based DV/SA organization. It’s also important to focus on the ultimate goal of protecting survivor/client information in a trauma-informed manner, and as prescribed in Colorado statutes.

If you have any questions or would like training or technical assistance (TTA) related to confidentiality and roles within a community-based DV/SA organization, please contact TTA staff at Violence Free Colorado.


“Navigating Roles and Service Provision” Confidentiality Webinar: https://www.youtube.com/watch?v=mWGVVkmkdlQ&t=2s

Contact us: info@violencefreeco.org
Learn more: www.violencefreecolorado.org