

CHAPTER VII: MENTAL HEALTH RECORDS

Disclaimer: The information contained in this chapter is not intended to be used as legal advice. Please refer to the most current specific state statutes and your own legal counsel when warranted. Some statutes may be referred to throughout this chapter.

INTRODUCTION

Mental health records are records that are generated as a result of contact between an individual and any mental health facility, agency, or program. This includes inpatient, residential and outpatient mental health programs. Such records contain “restricted” information and require additional protection as outlined in (34-B MRSA § 1207

Licensing regulations for mental health require adherence to the *Rights of Recipients of Mental Health Services* which outline specific rights afforded to mental health recipients (including specific rights for the control and maintenance of records above and beyond general state and federal law). There is a version for adults and one for children, and inpatient, residential, and outpatient services are addressed. *Rights* are monitored by the Department of Behavioral Health and Developmental Services (BDS) a division within the Maine State Department of Health and Human Services (DHS). Complete copies of the *Rights* may be obtained by contacting the DHHS at 207-287-4250.

DISCLOSURE GUIDELINES

In general, the guidelines for processing a request for information from a mental health record are the same as for any other record outlined in Chapter 2; however, there are additional requirements that apply to mental health records. In general, records are released only pursuant to a written authorization to disclose information signed by the patient or legally authorized representative (LAR) that specifically authorizes the release of information pertaining the diagnosis and/or treatment of mental health information. In addition, the authorization must include a statement that indicates that the patient realizes that he/she has the right to review the information prior to its release.

Absent written authorization, information may only be released in the following exceptions:

- When requested by DHHS to carry out a specific statutory function. Please note that requests by DHHS must indicate the statute that allows them to access such records.
- When necessary to allow investigation by the rights protection and advocacy agency.
- When necessary to allow investigation by the Office of Advocacy
- When necessary to allow investigation by DHHS for child protective matters.
- When necessary to allow investigation by DHHS for incapacitated adult protective matters.

- When ordered by a court of record subject to the Maine Rules of Evidence.
- Upon inquiry by law enforcement officials or treatment personnel in emergency situations when the patient's health or safety is at risk.
- When there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the patient on him or herself or upon another. (Tarassof exception)

In limited circumstances, a licensed mental health provider (note, not an HIM Professional) may disclose information regarding an inpatient's care to the patient's spouse or next of kin which includes diagnosis, admission to or discharge from a treatment facility, the name of any medication prescribed, sided effects of that medication, the likely consequences of failure to take the prescribed medication, treatment plans and goals, and behavioral strategies.

CFR 42, Federal Law, pertains to drug and alcohol treatment information and should also be consulted if applicable in the particular medical record. Substance abuse records are held to the strictest possible standards of confidentiality, and are not released without patient or LAR authorization except with a court order, in a medical emergency, for public health reporting, and in the Tarassof exception. As with any release of information, the minimum necessary to accomplish the stated purpose should be released.

HIPAA refers to exceptions for "Psychotherapy Records" and defines these as records of private notes kept separately from the Medical Record. See Chapter Two of the MeHIMA legal guide. Otherwise, HIPAA leaves issues pertaining to Mental Health Records to State Law.

COMPETENCY

The issue of a patient's competency may be raised in many situations where a decision has to be made; treatment, legal, financial, disclosure of information, etc. A declaration of incompetency is a legal matter and **MUST** be made via a legal court or administrative process after evidence is presented in a formal manner by clinical professionals. HIM professionals should consult legal counsel and the patient's physician with serious concerns about competency. Capacity has to do with whether a patient, in a particular moment, is able to make a specific decision, and is a more variable concept.

SUBPOENAS AND COURT ORDERS

Maine's mental health programs, under directive of legal counsel, may comply with a subpoena to appear at a deposition.. State mental health facilities sometimes do comply with a subpoena duces tecum to appear in court, but the facility's representative, before testifying, notes the confidentiality statute and asks for a court ruling about whether to testify. Follow your facility's policies and procedures for subpoenas and court orders. (Refer to Chapter IV: Subpoenas, Court Orders, & Depositions.) Copies of records are generally not produced without a court order and should not be brought to court without specific instructions to do so.

Generally, a DHHS investigative subpoena **IS** honored unless there is information pertaining to substance abuse which is protected by Federal law. Substance abuse treatment information is only

released pursuant to a court order signed by a judge and in certain other legally required instances (see above).

PATIENT ACCESS

As with all records, the patient has a right to access, review, and request a copy the medical record. The *Rights of Recipients* specify that patients must be permitted to review their records (supervised, if desired by the facility or provider, otherwise copies may be provided) within 3 business days of making the request. Access may only be denied when there is clinical justification that it would be detrimental to the patient's well-being. The justification for denial should be documented by the practitioner in these cases.

HIM professionals should not assume a provider's assent to release information is sufficient to compel the release, but should apply state and federal laws in addition to the input of the treating physician, if any. It is NOT required that every patient request for copies of records be reviewed by the treating clinician, although some facilities have instituted this practice. Generally, even if the clinician feels that denial of access is indicated, the record will still need to be released to a third party (attorney, advocate, etc.)

STUDENT ACCESS

Your facility's policies and procedures should define the process for student access and reviews of any medical records. The student should review these policies and should sign a confidentiality statement. It is recommended that students NOT be permitted to copy patient records for any reason.

TELEPHONE REQUESTS AND VISITORS

The fact that someone has received or is receiving treatment for mental health and/or substance abuse is unfortunately still stigmatizing and can have serious consequences to the patient. If a facility only provides mental health or substance abuse treatment, the patient's presence there tells something to a caller that is potentially damaging to the patient.

Therefore, facilities that specialize in these treatments do not confirm or deny a patient's presence in treatment to a caller unless the patient has given permission to do so. It should be assumed that the patient does NOT want the fact of his/her treatment revealed unless specific instructions have been given to the contrary. This is contrary to most acute care settings where the requirement under HIPAA is that patients be given the opportunity to "opt out" of a directory but failing that, the assumption is that the patient chooses to be included in the directory. This approach pertains to visitors as well.

In the outpatient setting, the same rules apply. It is recommended that appointment reminders not be left on patient answering machines unless the patient has agreed to this practice in writing, or the message can be left in a manner which does not reveal that the patient is receiving mental health treatment.

INFORMATION CONTRACTS AND INTERAGENCY AGREEMENTS

HIPAA requires that covered entities have Business Associate contracts with organizations with whom they share information about patients. In addition, as with all settings, patients must be informed about how their information is used via the organization's *Notice of Privacy Practices*. Organized Health Care Arrangements (OHCA) under HIPAA may share PHI. Again, this practice must be made clear to patients in the Notice of Privacy Practices. Patient requests not to share information with specific

providers within the OHCA or even within the organization should be honored to the extent possible, but false promises of confidentiality should not be made.

COURT-APPOINTED ADVOCATE

The court may appoint a special advocate or guardian ad litem in child abuse or custody cases, (See 4 M.R.S.A. § 1501), or in adult guardianship cases, (See 18-A MRSA, Article V, Part 3). The advocate or guardian is charged with serving in the best interests of the individual they represent. In this capacity, records of a confidential nature may be requested to enable the guardian ad litem to make decisions regarding care and treatment of the patient. As with any guardianship, written evidence of the appointment should be obtained prior to disclosure.

EMERGENCY TREATMENT

Signed consent to treatment is not required (but MAY be obtained if the patient is cooperative) in the case of an individual committed by a court to a mental health program. Written documentation in the patient's record by the treating practitioner of the patient's status (e.g., a copy of the "blue paper") is sufficient, (See Involuntary Commitment.) However, patients still retain the right to confidentiality of their records as discussed above. In addition, the *Rights of Recipients of Mental Health Services* allow for the disclosure of information necessary to obtain payment and perform operations with an "Administrative Release" signed by the CEO or designee.

EXPERIMENTAL TREATMENT AND RESEARCH

As for any patient, participation in experimental treatment requires the patient's written informed consent, including:

- an explanation of appropriate protections;
- procedures to be followed; and
- the benefits, risks and alternatives of the treatment.

In addition, HIPAA has very specific regulations about research activities, and generally an organization's institutional review board oversees any research activities undertaken at the organization.

INVOLUNTARY COMMITMENT

Maine law (34B M.R.S.A. § 3863) allows that a health officer or other person may make application for involuntary commitment when they believe that an individual is mentally ill and dangerous (poses a likelihood of harm) to self or others. The evidence to substantiate this belief must be stated on the application, which is also known as a "blue paper." The individual must then be examined by a licensed physician or clinical psychologist, who must verify as part of the application that the individual is mentally ill and poses a likelihood of harm. The application and certification must be endorsed by a judge. Within 24 hours of admission to a treating facility, another clinician must certify that there is a need for involuntary admission based on the above criteria. The commitment application and court documents should become part of the patient's health record.

The facility has three working days to determine if the application for involuntary commitment is

appropriate or if it is deemed that the patient would be best served by an informal voluntary status or by being discharged. . A patient may be discharged during this three day period if the physician feels it appropriate--i.e., if the patient no longer poses a danger to self or others.

In 2006 the Maine State legislature passed what is being referred to as the “Outpatient Commitment Law”. Certain “class members” (patients who had been at the Augusta Mental Health Institute) may be required to take prescribed medications as outpatients or return to an inpatient status. The details of this new law have yet to be operationalized, although some funds have been set aside for this interesting new program.

INFORMED CONSENT

All competent patients are guaranteed the right to consent to or to refuse treatment. In addition, the *Rights of Recipients* specifically grant this right to patients 14 years or older. Because of the potential for serious and/or permanent side effects, psychotropic drugs may not be initiated without written patient consent unless a psychiatric emergency is declared. The *Rights of Recipients* is clear about what constitutes informed consent, and that it is the provider’s responsibility to obtain it, and that patients 14 and older may not be medicated without their consent. For more information about consent for treatment, see Chapter 9 of the MeHIMA legal guide.

MAINE ADVOCACY PROGRAM

The Disability Rights Center is a private not-for-profit agency, the mission of which is to protect and advocate for the rights of persons with disabilities and to investigate grievances as mandated by federal and state statutes through:

- providing information about rights;
- referral to appropriate services;
- representing clients at meetings and hearings;
- investigating incidents of abuse and neglect; and
- providing training in legal and advocacy skills.

Access to health records by advocacy programs is allowed, provided that written consent of the patient or legal guardian is given, UNLESS:

- The patient is unable to provide consent by reason of impairment, and the patient does not have a guardian.
- The patient is a ward of the state.
- A complaint has been received by the system.
- There is probable cause to suspect that the patient has been subject to abuse or neglect.

Refer to the publications listed above for extensive definition of access and the exceptions as defined by Maine statute (34-B M.R.S.A. § 1207, sub-section 1). As with any unauthorized release of mental health or substance abuse information, legal counsel should be consulted and should guide in the development of policies regarding release.

REPORTING REQUIREMENTS

Mental Health and Substance Abuse records are not exempt from state reporting requirements.

However, care should be taken to release only the minimum information necessary. For instance, a clinician who is treating a patient for mental health and/or substance abuse issues is still required to report potential child or elder abuse situations, but that does not allow the release of any and all patient information which is still specifically protected. Again, it is suggested to consult with legal counsel whenever it is proposed that information regarding mental health or substance abuse treatment be released without the specific authorization of the patient or legal representative.

DECEASED PATIENTS

Mental Health/Substance Abuse treatment records are treated the same as any records once the patient is deceased. Consult Chapter III in the MeHIMA legal guide for further details.