



# MENTAL HEALTH MATTERS

*The newsletter of the Illinois State Bar Association's Section on Mental Health Law*

## Reporting under FOID Act

By Joseph T. Monahan

Illinois passed and enacted Public Act 98-63, effective July 9, 2013, which amended several laws, including the Mental Health and Developmental Disabilities Code ("Mental Health Code"), the Mental Health and Developmental Disabilities Confidentiality Act ("Confidentiality Act"), and the Firearm Owners Identification Card Act ("FOID Act"). Under the Act, physicians, clinical psychologists and qualified examiners are mandated to report to the Illinois Department of Human Services ("DHS") any person whom the physician, clinical psychologist or qualified examiner determines to pose a "clear and pres-

ent danger" to himself, herself or others, or determines to be "developmentally disabled." Additionally, mental health facilities are mandated to report the admission of individuals who are prohibited from obtaining a FOID card.

The Act was enacted for the purpose of restricting such individuals from possessing firearms. Even as we approach the two-year anniversary since enactment, there remains confusion among clinicians, hospitals and mental health practitioners as to how to comply with the re-

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## Parent with developmental disability discriminated against by Massachusetts in violation of ADA and Section 504 of the Rehabilitation Act

By Patti Werner

Only two days after giving birth to her daughter Dana, Sara Gordon<sup>1</sup> learned that her baby was being removed from her care. There was no allegation of abuse either before or after the birth. Instead, the baby was taken away based on a concern that Gordon was not able to comprehend how to handle or care for the child because Gordon has a developmental disability.

The Massachusetts Department of Children and Families (DCF) learned of Dana's birth and Gordon's "mental retardation"<sup>2</sup> and acted swiftly. Although Gordon demonstrated some difficulty taking care of the baby, her parents were available and willing to assist. They had even planned for Gordon and Dana to live with them. Nevertheless, despite a federal requirement and agency policy supporting reunification,<sup>3</sup> DCF placed

Dana in foster care, resulting in a plan to place the child for adoption.

Determined to be reunited with Dana, Gordon challenged the actions of the Massachusetts' child welfare agency, eventually enlisting the services of an attorney, and filing complaints with the Departments of Justice and Health and Human Services (DOJ and HHS, respectively).

According to the DOJ and HHS findings, DCF limited Gordon's visits with her baby and provided only minimal supports and opportunities for Gordon and Dana to be reunited. The findings indicated that DCF "repeatedly acted on its own assumptions about Ms. Gordon's disability" and "failed to individually analyze what services and supports would be appropriate, considering her

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## Reporting under FOID Act

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porting requirements. Attorneys representing physicians, hospitals, therapists and other medical and mental health practitioners must be aware of the requirements under the Act to properly advise their clients as to how to satisfy their duty to report.

### Reporting by Clinicians

The Act requires any physician, clinical psychologist or qualified examiner<sup>1</sup> to report to DHS any person whom the physician, clinical psychologist, or qualified examiner determines to pose a "clear and present danger" to himself, herself or others, or determines to be "developmentally disabled."

The report must be made within 24 hours of making the determination and must be made through the DHS FOID Reporting Systems Web site.<sup>2</sup> Information regarding the individual must remain otherwise confidential and privileged.

"Clear and present danger" is defined in the FOID Act as a person who:

- Communicates a serious threat of physical violence against a reasonably identifiable victim; or
- Poses a clear and imminent risk of serious physical injury to himself, herself or another person as determined by a physician, clinical psychologist or qualified examiner; or
- Demonstrates threatening physical or verbal behavior, such as violent, suicidal or assaultive threats, actions or other behavior, as determined by a physician, clinical psychologist, qualified examiner, school administrator or law enforcement official.

"Developmentally disabled" means a disability which is attributable to any other condition which results in impairment similar to that caused by an intellectual disability and which requires services similar to those required by intellectually disabled persons. The disability must originate before the age of 18 years, be expected to continue indefinitely and constitute a substantial handicap.

"Intellectually disabled" means significantly sub-average general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years.

One source of confusion for practitioners is the conflict between statutes as to how a

professional can fulfill his or her duty to report. The FOID Act and the Mental Health Code require the physician, clinical psychologist or qualified examiner to report directly to DHS. However, the Confidentiality Act allows them to report patients who pose a "clear and present danger" or are determined to be developmentally disabled to the professional's employer, who then must report to DHS, within 24 hours of the determination. From a risk management perspective for practitioners, it is best practice for physicians, clinical psychologists and qualified examiners to report directly to DHS themselves, rather than relying on their employer.

Practitioners are further confused by the requirement that any physician, clinical psychologist or qualified examiner report any individual who is determined to be developmentally disabled. There was confusion as to whether this required a retroactive determination such that, for example, a facility was required to evaluate all developmentally disabled persons in their program and report the individuals to DHS. There is no language in the Act to clarify this issue.

### Reporting by Mental Health Facilities

Mental health facilities must report to DHS within seven days after admission as an inpatient all persons who are prohibited from obtaining a FOID card, which includes the following:

- a person who has been a patient of a mental health facility within the past five years
- a person who had been a patient in a mental health facility more than five years ago who has not received the certification required under Section 8(u) of the FOID Act
- a person who is a clear and present danger to himself or herself, any other person or persons or the community
- a person who is intellectually disabled
- a person who has been adjudicated as a mentally disabled person
- a person who has been found to be developmentally disabled
- a person involuntarily admitted into a mental health facility

The definition of a mental health facility is much broader under the FOID Act than the Mental Health Code. For the purpose of re-

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porting to DHS under the FOID Act, a mental health facility includes any licensed private hospital or hospital affiliate, institution, facility or part thereof, which provides treatment of persons with mental illness. The definition specifically includes the following, or any parts of the following if they provide treatment of persons with mental illness:

- hospitals
- institutions
- clinics
- evaluation facilities
- mental health centers
- colleges
- universities
- long-term care facilities
- nursing homes

To qualify as a mental health facility, the primary purpose of the facility does not have

to be treatment of persons with mental illness. If the facility provides any treatment of persons with mental illness, it is considered a mental health facility.

Among mental health facilities, confusion arose as to whether a facility must report both the admission of an individual and an instance when the patient is determined to pose a clear and present danger. DHS regulations require multiple reporting. When a person is determined to pose a clear and present danger, the determination must be reported within 24 hours. If a person is determined to be a clear and present danger during his or her admission to a mental health facility, both a report of an admission and a report of a clear and present danger must be made.

The identity of the reporter will not be disclosed to the subject of the report, i.e., the patient. Additionally, the physician, clinical

psychologist or qualified examiner making determinations about the patient, and his or her employer, may not be held criminally, civilly or professionally liable for making or not making the notifications required under the Confidentiality Act, Mental Health Code or FOID Act, except for "willful or wanton misconduct." ■

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1. Qualified examiner as defined in the Mental Health Code. 405 ILCS 5/1-122.
2. <<https://foid.dhs.illinois.gov/foidpublic/foid/>>.

## **Parent with developmental disability discriminated against by Massachusetts in violation of ADA and Section 504 of the Rehabilitation Act**

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disability.<sup>4</sup> DOJ and HHS found that DCF's actions had the effect of discriminating against Gordon on the basis of disability, defeating the objectives of its reunification program, and denying Gordon and Dana the opportunity to be a family. DCF sought to terminate Gordon's parental rights, proceeding under a Massachusetts statute that allows a court to find a parent unfit if the parent has a condition, such as "mental deficiency" or "mental illness" which renders the parent "unlikely to provide minimally acceptable care of the child."<sup>5</sup>

These same prejudices, stereotypes and unfounded fears about people with developmental disabilities and mental illness are reflected in the Illinois statutory scheme that regulates the termination of parental rights. Among the statutory bases for terminating parental rights in Illinois is the "inability to discharge parental responsibilities" because of "mental impairment, mental illness or an intellectual disability" that is expected to extend beyond a "reasonable time period."<sup>6</sup> Parents with mental illness or developmental or intellectual disabilities have challenged Illinois' statutory scheme without success.<sup>7</sup> In one case, the Illinois Supreme Court stated:

Section 1(D)(p) does not, of course,

allow a finding of unfitness based on a mere showing of mental impairment, illness, or [intellectual disability]. Rather, the person's mental condition must render him unable to discharge his parental responsibilities and the inability to discharge parental responsibilities must extend beyond a reasonable time period. By definition, a child who is being raised by a person who is unable to discharge his parental responsibilities might not receive proper care.<sup>8</sup>

To permit termination of parental rights based on the "inability to discharge parental duties" without identifying those duties or defining how they are measured, invites the same kinds of presumptions and stereotypes that the DOJ and HHS found violated the ADA in the Massachusetts case. Statutes should provide "sufficiently definite standards" so that applying the law "does not depend on private conceptions."<sup>9</sup>

Private conceptions, presumptions, and stereotypes however, allow a parent with a mental illness or intellectual disability to be stripped of this most fundamental right<sup>10</sup> based on a concern that the child might not receive proper care. It is difficult to imagine

that Illinois lawmakers would impose such a standard on persons *without* a mental illness or a developmental or intellectual disability.

As we celebrate the 25<sup>th</sup> anniversary of the Americans with Disabilities Act<sup>11</sup> this summer, Illinois, Massachusetts and other states should remove disability references as a basis for terminating parental rights. People with mental illness and developmental disabilities should not have to wait another generation to keep their families intact. ■

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Patti Werner is Associate General Counsel for Presence Health.

1. The name provided in the DOJ/HHS report of investigation, but her name and the names of family members are pseudonyms. <[http://www.ada.gov/ma\\_docf\\_lof.pdf](http://www.ada.gov/ma_docf_lof.pdf)>.

2. Rosa's Law, Pub. L. No. 111-256, 124 Stat. 2643, substituted the term intellectual disability for mental retardation in federal law. Illinois followed suit in PA 097-227.

3. See Adoption and Safe Families Act of 1997, 42 U.S.C. § 671(a)(15)(B). The Act amended the Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500.

4. <[http://www.ada.gov/ma\\_docf\\_lof.pdf](http://www.ada.gov/ma_docf_lof.pdf)> at page 12.

5. Mass. Gen. L. c 210 § 3 (c)(vii)( 2012) (allows for termination of parental rights based on a condition which is reasonably likely to continue for a prolonged, indeterminate period, such as alcohol

or drug addiction, mental deficiency or mental illness, and the condition makes the parent or other person unlikely to provide minimally acceptable care of the child).

6. 750 ILCS 50/1(D)(p).

7. But see *In re N.F.*, 533 N.E. 2nd 952, 956-57(1989) (Nash, J., dissenting)(urging consideration of equal protection claim despite waiver based on statute's effect on persons with mental,

but not physical disabilities).

8. In re R.C., 745 N.E. 2<sup>nd</sup> 1236, 1242 (2001) (internal quotations omitted).

9. *People v. Molnar*, 222 Ill. 2<sup>nd</sup> 495, 524 (2006) (statute survives vagueness challenge where its prohibitions are sufficiently definite and provide sufficiently definite standards so that private conceptions do not drive its application).

10. See, e.g., *Meyer v. Nebraska*, 262 U.S. 390,

399 (1923) (recognizing the liberty interest in the 14<sup>th</sup> amendment included the right of the individual to marry, establish a home, and bring up children).

11. For information about the ADA's 25<sup>th</sup> anniversary, see: <[http://www.ada.gov/ada\\_25th\\_anniversary/index.html](http://www.ada.gov/ada_25th_anniversary/index.html)>.

## Sharing mental health records in Illinois: An overview of confidentiality concerns

By Dara M. Bass

**O**n April 10, the Illinois State Bar Association's Mental Health Law Section Council hosted a Continuing Legal Education program, titled, "When Can One Share Mental Health Records in Illinois? Issues Concerning Confidentiality of Mental Health Records". Both the live program and the live webcast were very well-attended. Following are some of the highlights from the program. Although a written summary cannot substitute for the dynamic and interactive presentations, this article provides an overview of the event. In the upcoming months, the Illinois State Bar Association will offer the video presentation in its collection of CLE programs.

Barbara Goeben, an attorney in the Legal Advocacy Service division of the Guardianship and Advocacy Commission, moderated the program. She represents clients at the trial and the appellate levels and has extensive prior experience with housing and poverty legal issues and has conducted direct legal outreach at homeless shelters. As she opened the program, Goeben emphasized the significance of confidentiality. She noted that mental illness is a leading cause of disability in the United States and poses issues for lawyers across numerous practice areas.

### "Professionalism: Confidentiality and representing persons alleged to have a diagnosed mental illness"

Joseph T. Monahan, the founder of the Monahan Law Group LLC and an adjunct Professor of Law at Loyola University Chicago School of Law, presented this segment. Monahan represents approximately 70 hospitals in the Chicago metropolitan area and has successfully argued multiple cases in the Illinois Supreme and Appellate Courts on

matters of confidentiality, mental health and child advocacy.

He assembled and provided a comprehensive outline. Monahan commented that all mental health records are confidential; however, the confidentiality is limited by waivers, exceptions and our expanded notion of when we can share, due to the Health Information Exchange. He advised counsel to obtain a court order when accessing records under an exception to the Confidentiality Act. He also informed that the mere fact that a person receives mental health treatment is, itself, confidential. He introduced the process in which an attorney seeking records must file a notice of petition to a provider, notice to the person whose records they seek, and then obtain a court order.

He elucidated some of the ways in which people other than a patient can access that patient's mental health records. For example, the Probate Act provides specifically for a guardian *ad litem* to access records but does not specifically state that counsel has access to records. He advises counsel to secure access through either a written authorization of the client or through a court order specifically authorizing counsel's access (even where counsel has been granted specific statutory powers to access). Also, an independent examiner may have access. Further, counsel might want to access records from other hospitals. He advises counsel to get written authorization to access the records of any other treatment providers.

He shed light on some mental health statistics. One in 20 adults live with serious mental illness such as schizophrenia and bipolar disorder. Fifty percent of mental illnesses begin by age 14 and 75 percent of mental illness develops by age 24. He also gave some

relevant facts, stating that mental illness ranges from serious mental illness to personality disorders and encompasses an array of diagnoses in between. Mental illness issues arise in multiple practice areas, including probate, criminal, domestic relations, juvenile court, estate planning and business law.

Monahan discussed the circumstance in which an attorney must order a formal, clinical assessment to determine whether a client can give informed consent for counsel's representation. He advised that the American Bar Association provides attorneys with excellent guidelines for assessing their clients, who may view the mere request for assessment as traumatic.

Monahan also turned to the Illinois Rules of Professional Conduct. He reminded that they provide guidance on how to navigate confidentiality in light of a client with diminished capacity. Specifically, Rule 1.14 and Rule 1.6 shed light. They illuminate when a lawyer *may* reveal information and when a lawyer *shall* reveal information. He advised that attorneys who contemplate revealing the information should get consultation of another lawyer without disclosing the client's name.

Focusing on some of the settings in which the mental health records are not confidential, Monahan discussed *Johnston v. Weil*, 241 Ill.2d 169, 183-84 (2011), which he argued before the Illinois Supreme Court. In this case, the court determined the records were not confidential because no therapeutic relationship existed. Further, court-ordered evaluations are not confidential. Sometimes courts consider whether a patient has relied upon an "expectation of privacy."

Monahan next focused on a therapist's personal notes. He said that when a provider

refuses to tender personal notes, they must go to a judge who will decide whether they meet the necessary content criteria of personal notes.

He noted that attorneys must sometimes make decisions about whether they should disclose confidential information. Under some circumstances, you *may* disclose to law enforcement and under others, you *must* disclose to law enforcement. Professionals have an obligation to report child and elder abuse and should use the hotline to determine whether or not it's appropriate to report child abuse. Elder abuse law now includes persons with disabilities. So professionals must also report abuse of disabled individuals.

Monahan warned that people erroneously believe the HIPAA order gives them the right to access confidential information. Specifically, he warned of HIPAA orders that allegedly allow people to access confidential information and strongly cautioned attorneys to carefully read the HIPAA orders.

He advised of some other special instances where confidentiality is not outright and some additional areas of concern. For example, 12-year-olds have a right to consent to disclosure in many instances, though this right is not *carte blanche*. Court-ordered evaluations, such as those conducted pursuant to Illinois Supreme Court Rule 215 and Section 604(b) of the Marriage Act (750 ILCS 5/604(b)), are not confidential. He advised attorneys who represent two individuals in the same matter to consider whether a conflict of interest exists and recommends they get a waiver from both people. He advises therapists to maintain separate records for each individual person they treat in a group therapy setting. Some medical issues intersect with mental health issues and garner higher protections than mental health records. A couple of examples are drug and alcohol records and HIV/AIDS records. Professionals are not allowed to re-disclose records (unless the order is very specific).

### **"Should this information be disclosed?"**

Attorneys Robert J. Connor, Patricia A. Werner, and Andreas M. Liewald spoke about different facets of whether the information should be disclosed. They individually presented and then collectively fielded questions.

Robert J. Connor is a Deputy General Counsel with Department of Human Services, which he has represented for over 30

years. His rich experience includes work in areas such as mental health law, developmental disability and rehabilitation service laws. His expertise is in the area of confidentiality of records. He has conducted legal review of the new databases which aggregate the private data of mental health consumers.

Connor provided a copy of Public Act 098-1046, which addresses HIV/AIDS and genetic information. He stated HIV/AIDS and genetic counseling information will now fall under the HIPAA confidentiality exceptions for treatment, health care operations and payment. He believes the Act is a template for what will probably happen to the Mental Health Code. Connor stated that no such HIPAA exceptions exist for mental health records. He provided a couple examples of exceptions that do exist, such as disclosures for coordination of care. But neither one arises under HIPAA. If state law is stricter, then courts will apply the state law. The Confidentiality Act for mental health records is, indeed, stricter. Because the Illinois Health Information Exchange (HIE) is not yet operational, the state law remains stricter.

Connor outlined three purposes that Public Act 098-1046 achieves for HIV/AIDS and genetic information: 1) it creates a limited data set, 2) it permits for de-identified data, and 3) it permits research on either one of the above. He informed that research already plays a role with mental health records through one clear exception to confidentiality; under the Mental Health Confidentiality Act, the Department of Human Services can share mental health information with the University of Illinois' Institute of Juvenile Research and Institute of Developmental Disabilities. Research and data are becoming increasingly important in the medical field. Data collection poses risks in terms of protecting the data once it enters a database.

Connor advised on a remedy that will become very significant when new exceptions to the Mental Health Confidentiality Act are implemented. Aggrieved parties, whose confidentiality has been breached, may sue for damages, injunction or other appropriate relief, under 740 ILCS 110/15, which is the state law that will continue to apply.

In addition, Connor explained how the increasing use of electronic medical records has promoted reliance upon "metrics," which is a statistical manipulation of a group or analysis of an individual person. Data from mental health records often results in scoring or ranking patients in terms of various factors, such as their likelihood of recidivism or

re-hospitalization. Yet, Connor pointed out, patients are unable to access their own data and the scores that may result from it. He suggests we introduce a patient bill of rights, similar to a consumer bill of rights, whereby patients would have rights to see their own metrics analysis.

In terms of mental health records flowing from one medical provider to another, Connor favors carving out an exception for this limited treatment purpose. However, he believes we need to preserve all of the other protections.

Patricia A. Werner, associate general counsel at Presence Health, was the next presenter. Having worked at Community Integration at Access Living as a managing attorney, and at the Legal Advocacy Service of the Illinois Guardianship and Advocacy Commission, she has devoted a significant part of her career to representing people with mental illnesses and developmental disabilities.

Werner began by sharing that the World Health Organization estimates that by the year 2020, mental health and substance use disorders will surpass all physical diseases as a major cause of disability worldwide. She underscored the importance of privacy: as an essential element in the therapist-patient, it promotes treatment. Stigma influences our desire to protect these records, but also frequently impacts healthcare workers' treatment decisions. Patients would benefit from treating mental health care more like the rest of healthcare.

Although many people endeavor to harmonize the Confidentiality Act with HIPAA, Werner noted that many others resist the movement, with good reason. HIPAA and the Confidentiality Act differ in their approach to a patient's records, post-mortem. Under the Confidentiality Act, records may not be disclosed after a recipient's death unless a relative, as defined in the Probate Act, and the therapist consent to that disclosure or a court authorizes the consent after reviewing those records *in camera*. HIPAA and the Code of Civil Procedure were amended to allow for greater disclosure. She advised attorneys to read the HIPAA orders and requests.

In terms of law enforcement's role, disclosure to law enforcement may or may not be appropriate in given instances. Werner mentioned various instances where law enforcement involvement may or may not be best. She dispelled the myth of a "police hold," which would authorize medical and mental health providers to notify the police within

24 hours of a patient's discharge. Even in cases where illegal substances are involved, hospitals and mental health care providers maintain a unique role from the police.

Werner informed that some instances permit providers to disclose to law enforcement. For example, in the case of a missing person, providers may tell law enforcement that the person is under their care. However, if the patient has voluntarily admitted himself, they must obtain the patient's consent. In any event, providers should first try talking to that patient and offering that the patient, himself, notify law enforcement. Such a measure is one way to help preserve patient dignity. Providers may disclose to law enforcement that they are caring for a patient who matches the description of a felony or sex offense case perpetrator.

Werner believes that therapists' duty to warn includes a duty to notify law enforcement. The Confidentiality Act states disclosure is needed to warn or protect a person who is the subject of a threat. But therapists can also notify law enforcement as way to ameliorate the threat.

Other instances when disclosure may be appropriate is when one seeks to initiate or continue a civil commitment or involuntary treatment. Further, professionals are mandated reporters, who must disclose to report abuse and neglect.

Werner noted some special instances where disclosure is not appropriate, such as in the case of minors aged 12 to 18. Adolescents have a stake in their treatment. Further, people who are restrained against minors under orders of protection may not access that minors' records.

HIPAA and the Confidentiality Act are increasingly providing for disclosure for treatment purposes, which Werner views as a positive movement. Now under the coordinated care exception, the disclosure eases patients' transition from one care facility to another. It is also useful in event that the client does not sign an authorization.

Andreas Liewald presented the final part of the programming about whether the information should be disclosed. An attorney for Legal Advocacy Service, he is court-appointed to represent respondent consumers in involuntary admission and involuntary treatment hearings in Cook County and Madison County. He has over 20 years of experience with this type of representation. Previously, Liewald concentrated in fam-

ily law while working at Legal Aid Society of Metropolitan Family Services.

Liewald addressed many issues surrounding the confidentiality of mental health records within the court system. For example, whenever a petition for involuntary commitment is filed or a petition for medication is filed under the Mental Health Code, the records are protected under Section 2 of the Confidentiality Act.

He directed participants' attention to the Mental Health Code. In terms of the court hearings, themselves, 405 ILCS 5/3-800 provides that a respondent can request the hearing be closed to the public and it provides language that protects respondents' confidentiality. Liewald provided a copy of *In re Michael D.*, 306 Ill.App.3d 25 (1st Dist. 1999), in which the Appellate Court held the language of Section 3-800 is mandatory.

In terms of mental health records, Liewald informed that the Confidentiality Act, in 740 ILCS 110/4(c), allows a client a number of remedies for inaccuracies or omissions within his records. A patient may take action where he believes that providers have made erroneous diagnoses or have missed references to adverse medication reactions. Liewald provided a sample letter regarding disputed content within the medical records and sample statements concerning new and disputed information, which previous clients had prepared. Providers must enter such a written statement into the client's medical records.

When a social worker listens on a phone call about a patient's treatment plan and acknowledges that the patient is under his care or treatment, an exception to confidentiality exists. Also, a client, who is the subject of a guardianship order, who wants to receive records, is not precluded from accessing his mental health records on account of being under the guardianship order.

Liewald discussed the scenario when a client is found subject to involuntary commitment but less restrictive alternatives are available. However, when a client is unable to the disclosure of records (for the purpose of securing funding, benefits, making other arrangements and contacting social services), an exception exists.

### **How can I get this information?**

Scott D. Hammer next spoke about how attorneys should properly issue subpoenas for mental health records. He frequently responds to subpoenas that parties have is-

sued to therapists.

Hammer has concentrated his practice for over 30 years on representing mental health professionals. He is a past Chairman of the Chicago Bar Association's Mental Health and Disability Law Committee and he is the current Chairman of the ISBA's Mental Health Law Section Council. He is of counsel to the national litigation law firm, Wilson, Elser, Moskowitz, Edelman & Dicker, LLP.

Hammer provided printed materials and spoke about an example of a probate case: an attorney had to test the capacity of a client who amended his estate in a way that suggests he may have been subject to undue influence. He highlighted the ways in which mental health issues impose upon various practice areas.

Regarding subpoenas for mental health records, attorneys must strictly follow the Confidentiality Act, which has been recently tweaked in ways that affect mental health records. A HIPAA order should state that the Mental Health Confidentiality Act must still apply.

Hammer pointed out that general assemblies and courts have shown the importance of keeping mental health records confidential. The first time the United States Supreme Court recognized the doctor-patient privilege for mental health records was in the case of *Jaffe v. Redmond*, 518 U.S. 1, 10, 116 S. Ct. 1923, 1928, 135 L.Ed.2d, 337, 345 (1996), which is a case that arose in Hoffman Estates. The court noted that confidence and trust are needed for disclosures and that psychotherapists have a unique relationship with their patients. The trial court said the records were not privileged. The appellate court reversed and the Supreme Court upheld. All 50 states have a psychotherapist-patient privilege either by statute or by common law.

Recent changes in the Confidentiality Act make it easier than ever to obtain mental health records. Most attorneys (and judges) are not aware of these developments. However, the Confidentiality Act maintains that a recipient of mental health service has a right to refuse disclosure.

Hammer drew attention to Section 10 (d) of the Confidentiality Act, which provides specific instructions for how to issue subpoenas. Although the law formerly required attorneys to get an order by a judge, the new law permits the written consent of the patient. Attorneys have a choice, with the written authorization being easier. When at-

torneys file motions, they have to give notice to the plaintiff's attorney and to the patient, himself. An *in camera* inspection is permitted. The HIPAA authorization does not comply with the Confidentiality Act and people issuing subpoenas must write the rule on the face of the subpoena.

The authorization must enumerate numerous points like the purpose, the consequences of refusing to consent, and the calendar date when authorization expires. Further, Section 5 of the Act provides that the signature must be witnessed.

Mental health professionals must adhere to these rules when they issue the subpoenas and when they comply with them. Attorneys knowingly violate the Act if they don't follow them. The Confidentiality Act provides penalties for those who do not strictly comply with the Confidentiality Act. Section 15 allows persons aggrieved by a violation of the Act to sue for damages. Section 16 prescribes criminal penalties.

This issue has been litigated in *Mandziara v. Canulli*, 299 Ill.App.3d 593, 701 N.E.2d 127, (1st Dist. 1988), which is a divorce case, from which a case arose against an attorney for not properly filing. It stands for the tenet that you must possess a written order to accompany the subpoena. Where a doctor complies with a state-issued subpoena in the absence of a court order or an authorization, the doctor does violate the law. Hammer provided a sample subpoena and order, which he uses in his practice.

#### **"Mental health records in the age of the health information exchange"**

Cheryl R. Jansen presented the final portion of the program. She is the Legislative Policy Director at Equip for Equality in Springfield, Illinois. She enforces due process and advocates rights for people with disabilities, who face discrimination, noting that significant stigma and shame surround mental illness. Physical complaints are often dismissed due to a comorbid mental illness.

Jansen placed the Confidentiality Act in perspective. It has existed for decades, prior to the advent of electronic health records, and was a huge accomplishment when it was passed. Section 5 of the Mental Health and Developmental Disability Confidentiality Act requires the signed, written consent of a person entitled to inspect and copy a recipient's mental health records. Jansen listed the requirements for the consent.

In 2010, Illinois enacted the Health Infor-

mation Exchange Act to promote the sharing of electronic records in Illinois and other states. With quick and easy access to records, the goal was to improve, increase efficiency, and reduce medical errors and costs.

Jansen explained that states have had three basic options in terms of how they would deal with sensitive information in the context of an exchange. Regarding the first option, Illinois has claimed it lacks the technology to code categories of sensitive information and withhold some from the exchange. Second, a state could adopt an opt-in policy, where patients would be given a choice of sharing mental health records only if they opt-in. Finally, a state could do an opt-out policy, like Illinois does.

The 2013 amendments to the Confidentiality Act allow certain entities to use information for the Health Information Exchange purposes without the recipients' consent. However, therapist notes under the Confidentiality Act are not a part of the record, even under the amendments.

Further, Jansen illuminated the fact that

recipients retain many rights. For example, recipients have a right to revoke a prior decision to opt-out or a decision not to opt-out. Providers must give recipients "meaningful disclosure" regarding the Illinois Health Information Exchange (ILHIE). Recipients are entitled to written notice that sets forth a number of important facts and parameters. Patients should look for this notice and should ask whether a provider is a part of the ILHIE. Despite the amendments and the new provisions, no rules currently exist to implement the ILHIE.

Ultimately, recipients are forced with the choice of being "all-in" or "all-out." This choice could be a big issue for people getting mental health treatment and could thwart the purpose of promoting coordinated care. ■

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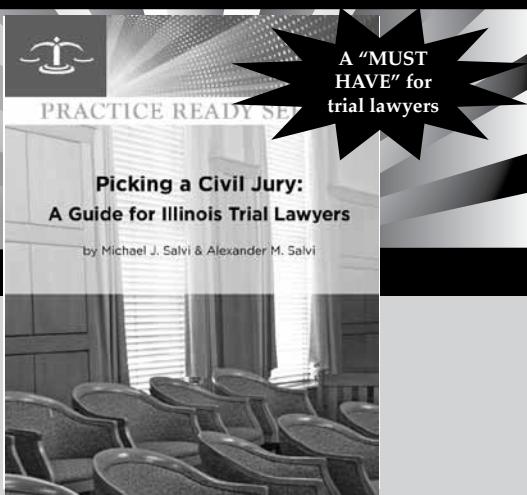
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