

# Confidentiality or Communication in the Treatment of the Mentally Ill

ROBERT D. MILLER, MD, PHD\*

## Summary

Along with rights to receive and refuse treatment, and treatment in the least restrictive environment, confidentiality of patient records has begun to receive more attention by both legal and mental health professionals. Most of the attention from psychiatrists has concentrated on increasing restrictions on releasing patient information, particularly to third-party payors and in court. One area in which fewer restrictions on information transfer need to exist, however, is that of treatment in the public mental health system, where communication among all facilities, both state and local, is absolutely essential for effective treatment. Many legislatures and courts do not yet recognize this need, and obstruct it in the name of protection of the patient's privacy.

Patients' rights have been of increasing concern in medical care over the last decade. The common use of the words "client" or "consumer" instead of "patient" reflects the growing pressure to regard physicians as providers of services rather than as professionals responsible for the care of their patients.

Nowhere are these issues more debated than in the public systems of mental health care, both because of their higher visibility and because of the coercion involved in involuntary commitment. Courts and legislatures have recognized basic human rights to treatment,<sup>1,2</sup> treatment in the least restrictive environment<sup>1,3</sup> and the right to refuse treatment.<sup>4-5</sup>

The most recent area of interest is that of confidentiality. Recent decisions have both increased and decreased it: many states have passed laws allowing patients access to their own medical records, and four bills currently in the US Congress would provide the same right nationwide.<sup>6-7</sup> On the other side, the Tarasoff decision, requiring therapists to warn potential victims as a result of patient revelations in psychotherapy, while unofficial outside California, has had an increasing negative impact on the supposedly confidential nature of patient-therapist communication.<sup>8</sup>

Most clinicians would agree that increased protection of patient confidentiality is in the best interests of their patients. There continues to be a

---

\*Dr. Miller is Director of Residency Training and Clinical Research at John Umstead Hospital in Butner, NC and Clinical Assistant Professor of Psychiatry at Duke University Medical Center.

basic conflict between the legal profession and psychotherapists over whether or not information given during psychotherapy should be privileged in court.<sup>9-16</sup> In the area of communication among therapists working with the same patient, however, considerable disagreement remains, even among clinicians.

In the private sector of mental health care, there are few problems concerning protection of patients from unauthorized disclosure of information to other professionals. Psychotherapy in private outpatient settings is usually a voluntary arrangement on both sides, and if information from previous therapists is necessary, such communication can be made part of the therapeutic contract between the therapist and patient.

Such a relationship would fall under Hollender's "patient-oriented therapy" category, in which the therapist is responsible only to the patient.<sup>9</sup> In such situations, it makes both clinical and legal sense for the patient to control all access to confidential information. With involuntary committed patients, most of whom are treated in the public sector of care, the relationship is more complex; as with Hollender's "society-oriented therapy"<sup>9</sup> the therapist is more often following goals other than the patient's. Many have questioned the very existence of involuntary commitment in any circumstances, and especially if there is no demonstrable immediate danger.<sup>17-18</sup> Nevertheless, current legal thinking, both in state legislatures and in the courts, is that states have a legitimate interest in the commitment of persons for treatment of mental illnesses, under police power provisions if they pose potential danger to others and under *parens patriae* if they are dangerous to themselves.<sup>2,19-20</sup> As long as these provisions remain in effect, involuntary hospitalization will continue to be employed for a significant number of patients; although hospital censuses are down, admission rates are up across the country.<sup>21-22</sup> Advocates of deinstitutionalization and treatment in the least restrictive environment have worked diligently to provide community-based treatment as a viable alternative to involuntary hospitalization; however, without adequate communication among members of the public sector of mental health care, these efforts will continue to be ineffective, resulting in patients suffering more loss of freedom and privacy through repeated hospitalizations.

These problems are not significant for voluntary patients, who generally cooperate with treatment, including aftercare, but for committed patients (who constitute over two-thirds of all patients admitted to state hospitals in North Carolina, and continue to represent a significant percentage of admissions across the country) the question is not **whether** to restrict privacy, but **how** to do it most beneficially and with the least intrusion. Since most communities have made it clear that they are not ready to accept the behavior of many chronically mentally ill persons, those persons will be subject to intrusions on their privacy. The real questions are whether those intrusions should restrict the right to prevent sharing of information without

consent, or the right to freedom from unnecessary involuntary hospitalization.

Most guidelines, regulations and laws which address the confidentiality of patient information clearly permit sharing of clinical data regardless of patient consent within a single facility, such as a hospital or a clinic. That same ability to communicate is not typically permitted among the various components of public mental health systems. Traditionally, most State mental hospitals have been, and continue to be administered by State governments, while community mental health centers (CMHCs) are mandated by the Federal government to be locally controlled if they are to receive Federal funds. Therefore, despite the clear clinical and legislative intent that there be one unified system of public mental health care, the various components are administratively separate, and sharing of information without patient consent is usually prohibited or at least severely restricted.

North Carolina passed a bill in 1979 which permits a treatment facility to share information without consent with another facility, but only if the other facility has referred the patient, and only after the other facility requests the information.<sup>23</sup> Despite the "one portal of entry" concept of public mental health care, most patients admitted to State hospitals, at least in North Carolina, are still not directly referred by CMHCs, which do not have sufficient staff and funding to operate 24 hours a day, seven days a week.

Limitations on information sharing place further burdens on the CMHC's ability to deliver services to the most severely impaired segment of the population, the chronically mentally ill, many of whom do not or cannot seek help at the center by themselves. Without services, these patients' conditions deteriorate, and frequently necessitate another involuntary commitment to a State hospital. Although current therapies are effective with many of these patients, once they leave the hospital, they are often unwilling or unable to follow through with aftercare on their own, and deterioration and regression reoccur, generating the "revolving door" syndrome of repeated hospitalizations. Lack of appropriate information at CMHCs is a major factor in this syndrome; followup rates for patients discharged from public psychiatric hospitals vary from seven to 45% nationwide.<sup>24</sup> CMHCs must be aware of patients from their catchment areas when they are hospitalized, help provide the data base for the hospital treatment plan, participate in discharge planning and be prepared to receive the patient upon discharge, or to implement outreach services for those patients who cannot or will not come to the clinic.

Another major reason for patients going into regressions from their illnesses is frequent changes in medication due to lack of communication among the clinicians treating them; this common practice is disrupting both biologically and psychologically, and reinforces the patient's own feelings of confusion and helplessness.

None of these clinically necessary goals can be reached without full cooperation and information sharing among all treatment facilities working with each patient. The concept of a case manager for chronically ill patients, which has been quite successful in working with the mentally retarded, also absolutely depends upon sharing of information among all facilities. In addition to clinical necessity, the new Consolidated Standards for Psychiatric Facilities of the Joint Commission for Accreditation of Hospitals require each hospital to provide aftercare for each discharged patient through direct contact and/or assistance from other community human service resources, and to document the results of aftercare planning by checking with the community service resources at appropriate intervals after discharge, regardless of whether the patient signs consent, or whether the patient had been referred by or ever seen at the community facility.<sup>25</sup>

The right to privacy of one's medical records, like the right to refuse treatment, is one of those basic human rights which seem self-evident when viewed in a vacuum, particularly if the legal assumption that everyone over age 18 is competent to make decisions until proven otherwise in court is made. In practice, however, the very illnesses which necessitate treatment, particularly involuntary hospitalization, often impair patients' abilities to recognize the need for treatment, and the concomitant need for sharing of information. Some authors allude to this dilemma, but there is no good discussion of it in the literature.<sup>9-10,15,26</sup> Schlensky even proposes that all sharing of information without patient consent be prohibited.<sup>27</sup> By over-zealously protecting one right, such as privacy, a greater right, that of effective treatment and relief from misery, is abrogated. Nor is this an insignificant problem: on my adult admissions unit alone, some 400 patients refuse to sign consent to release information each year; assuming similar percentages at similar State hospitals in North Carolina, over 3,000 patients would be involved statewide. Since these patients are usually among the most chronically and severely ill, they are the very ones for whom sharing of information is the most important.

If society intends to provide public services to the mentally ill, particularly involuntary forms of treatment, then it should not hobble those efforts at their outset by restricting the methods necessary to deliver effective and timely treatment. Otherwise, there will be a return to the days of simple incarceration of the mentally ill, a greater tragedy now that we have methods of alleviating most of the illnesses.

The simplest solution would be for the various states with administratively separated public systems of mental health care to consolidate these systems; not only would this resolve the confidentiality problems, but would greatly simplify all aspects of mental health care. Unfortunately, with the political power struggles over funding and control which exist between State departments and legislatures on the one hand, and county commissioners on the other, this is unlikely in most states. The courts and legisla-

tures need to respond with enabling decisions and legislation to permit clinicians to provide all the currently available services, recognizing the principle of one system of care, even when it is yet far from a practical reality. The provisions of several bills now before the US Congress would seem to permit such freedom of information sharing; those sections should be vigorously supported despite other sections which are far more controversial for clinicians.<sup>7</sup> Similar efforts must be made at state levels, to inform lawmakers of the urgent need to develop closer liaison among all public facilities charged with serving the largest segment of the population in need of health care services, the chronically mentally ill.

There will always be a risk involved in granting professionals in any field greater freedom to affect the lives of those they serve; mental health professionals have been guilty of excesses, just as have other groups. The right to privacy, increasingly invoked to establish rights to refuse treatment as well as confidentiality, is crucial for psychiatric patients. Divulging not only personal information, but the very fact of psychiatric treatment, especially hospitalization, can be very damaging to patients because of persistent community misconceptions and prejudices about mental or emotional problems. Any proposal which advocates wider dissemination of identifying and personal information without explicit consent must include methods for protecting patients from unnecessary disclosures. The decision to share information should not be automatic, but should be decided on a case-by-case basis.

One example of potential abuse at one North Carolina State facility involved a prominent attorney who travelled many miles to receive treatment at an Alcohol Rehabilitation Center far from his home. Upon discharge, he requested that no information be given to any treatment facility in his home community because of potential damage to his professional reputation. Similar situations occur frequently, especially in rural communities where it is harder to maintain anonymity. Legal avenues of insuring protection from such possible intrusions are not only cumbersome and time-consuming, thus placing further obstacles in the path of rapid and effective treatment; they may also in themselves be intrusive and more revealing of confidential information than clinical communication, especially in the case of guardianship proceedings.

Another risk of sharing information without patient consent is a worsening of the therapist-patient relationship, which is often already strained by the adversary nature of the civil commitment process.

The best solution to all of these problems is for the therapist to develop a better relationship with the patient, within which such issues as consent to share information and to receive treatment will cease to be problems. Staff working with committed patients have for too long omitted to allow their patients a significant part in clinical decision-making. There will continue, however, to be instances in which patients will refuse to authorize sharing of information which is absolutely necessary to insure continuity of care and to

prevent remissions and rehospitalizations. North Carolina statutes now mandate such communication in cases of commitment to outpatient treatment, but this represents a very small percentage of patients who need aftercare, particularly outreach and other preventive services.

Another important point is that information should not be shared without patient consent, even under color of statute or regulations, unless a true "need to know" can be established. Therefore, even with consent, or in cases of information sharing within a single facility, no information should be transmitted just because it is permitted; confidential information should not be routinely transmitted unless there is strong clinical or other justification for the receiving party's need to know that information.<sup>28</sup> Keeping this principle in mind will go a long way towards preventing abuses of information sharing.

If clinicians are judicious in their use of such communication without patient consent, then the benefits of continuity of care may be reaped at a minimum of risk to the patient.

#### References

1. Wyatt v. Stickney, 325 F Supp., 781 (MD Ala 1971).
2. O'Connor v. Donaldson 95 Supreme Ct. 2486 (1975).
3. Rouse v. Cameron 373 F 2d 451 (DC Cir. 1966).
4. Rennie v. Klein 462 F Supp 1131 (D NJ 1978).
5. Rogers v. Okin No. CA 75-1610-T (D. Mass. 1979).
6. North Carolina Confidentiality Regulations, 10 NCAC Subchapter 18D.
7. S. 503; S. 865; HR 2979; HR 3444; all in 96th Congress.
8. Tarasoff v. Regents of U. California 529 P. 2d 553 (Sup. Ct. Ca. 1974).
9. Hollender, M.H.: Privileged Communication and Confidentiality. *Dis. Nerv. Sys.* 26:169-175, 1965.
10. Dubey, J.: Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy. *Am. J. Psychiatry*, 131:1093-1096, 1974.
11. Joling, R.J.: Informed Consent, Confidentiality and Privilege in Psychiatry: Legal Implications. *Bull. Am. Acad. Psychiatry and Law* 2:107-110, 1974.
12. Sadoff, R.L.: Informed Consent, Confidentiality and Privilege in Psychiatry: Practical Applications. *Bull. Am. Acad. Psychiatry and Law* 2:101-106, 1974.
13. Redlich, F. and Mollica, R.F.: Overview: Ethical Issues in Contemporary Psychiatry. *Am. J. Psychiatry* 133:125-136, 1976.
14. Slovenko, R.: On Confidentiality. *Contemp. Psychoanalysis* 12:109-139, 1976.
15. Meissner, W.W.: Threats to Confidentiality. *Psych. Annals* 9:54-71, 1979.
16. Perr, I.N.: Doctor-Patient Confidentiality—Suggested Legal Protection. *Bull. Am. Acad. Psychiatry and Law* 7:iv-viii, 1979.
17. Szasz, T.S.: *Law, Liberty and Psychiatry*. MacMillan, New York, 1963.
18. Ennis, B.: *Prisoners of Psychiatry*. Avon, New York, 1972.
19. Lessard v. Schmidt 349 F. Supp. 1078 (E.D. WI 1972).
20. Addington v. Texas 99 S. Ct. 1804 (1979).
21. Aviram, U. and Segal, S.P.: Exclusion of the Mentally Ill. *Arch. Gen. Psychiatry* 29:126-131, 1973.
22. Miller, R.D.: Beyond the Old State Hospital: New Opportunities Ahead. *Hosp. Comm. Psychiatry* 32:27-31, 1981.
23. North Carolina General Assembly Session 1979 Chapter 147, House Bill 415.
24. Joint Commission on Accreditation of Hospitals, personal communication.
25. Section 15, Consolidated Standards for Child, Adolescent and Adult Psychiatric, Alcoholism and Drug Abuse Programs. Joint Commission on Accreditation of Hospitals, Chicago, 1979.
26. Noll, J.O. and Hanlon M.J.: Patient Privacy and Confidentiality at Mental Health Centers. *Am. J. Psychiatry* 133:1286-1289, 1976.
27. Schlensky, R.: Informed Consent and Confidentiality: Proposed New Approaches in Illinois. *Am. J. Psychiatry* 134:1416-1418, 1977.
28. North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse Services: Regulations on Confidentiality of Client Records, 1979. □