LIMITS OF CONFIDENTIALITY - JUVENILE FACILITIES UNDERSTANDING AND AGREEMENT

State Form 54394 (8-10)

DEPARTMENT OF CORRECTION / MENTAL HEALTH SERVICES

State and federal law protects the privacy of some, but not all, communications between a student and a mental health professional. In the juvenile setting, all personnel are considered part of the treatment team and may be permitted access to the health record (HR). However, the Health Care Administrator controls access to the HR and therefore only staff persons who have a need, in the course of their assigned duties, to use mental health information found in the HR shall have access to them. For instance, a facility janitor or librarian would not be allowed to read a student's health record without permission because to do so would not be part of their assigned duties, so information would be confidential. Importantly, short of the Superintendent or his/her designee or an emergency situation, all Custody staff must get permission to access the HR and even when custody staff have permission, their access is restricted to the information which they need to perform work related tasks. For example, a Custody officer would not be allowed to access a student's HR simply to read whether anything negative was said in-session about that officer.

In most situations, I can only release information about your treatment to others outside of the correctional facility if your legal guardian, the [redacted] signs a written Authorization form to do so. However, in the following situations, no authorization is required *(please initial)*:

______ During your incarceration, the Superintendent is your legal guardian and has the right to examine all of your medical and mental health records at any time. However, the Superintendent has been encouraged to first consult with and/or review the record in the presence of the treating mental health professional.

______ I may occasionally find it helpful to consult other correctional staff, family members, or other healthcare professionals about your treatment. During a consultation, I make every effort to avoid revealing the identity of my student. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your HR.

______ Any IDOC staff member or contractor may receive confidential health record information if that information is necessary to the performance of his or her responsibilities for the IDOC. The Administrative Review Committee (ARC), an IDOC entity, makes decisions regarding the release of juvenile offenders and the conditions of such releases. In order to make informed decisions and determine appropriate placements, the ARC often needs information relating to the mental health of the student under consideration. To this end the ARC reviews available records and often requests either assistance with interpretation or additional information. The ARC does not ask Health Services Division personnel for advice regarding the decision to release and does not accept it if offered. When the ARC requests clinical information it shall be provided if it exists.

______ You should be aware that the State or its contractors may employ clerical staff to manage aspects of the Mental Health Department, This person has been given training about protecting your privacy and has agreed not to release any information outside of the facility without the Superintendent's permission. Other individuals may also join the staff. Any new staff member will be given training about protecting your privacy and will agree not to release any information outside of the facility without the Superintendent's permission.

______ If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the mental health professional - client privilege law. I cannot provide any information without your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

______ If a government agency or accrediting organization is requesting the information for health oversight activities, I may be required to provide it for them.

______ To a coroner or medical examiner, in the performance of that individual's duties.

______ If a student's legal representative files a complaint or lawsuit against me, I may disclose relevant information regarding that student in order to defend myself.

LIMITS OF CONFIDENTIALITY - JUVENILE FACILITIES UNDERSTANDING AND AGREEMENT *(continued)*

State Form 54394 (8-10)

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a student's treatment *(please initial)*:

______ If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, the law requires that I file a report with the Indiana Department of Child Services. Once such a report is filed, I may be required to provide additional information.

______ If I have reason to believe that someone is an endangered adult, the law requires that I file a report with the appropriate government agency, usually the adult protective services unit. Once such a report is filed, I may be required to provide additional information.

______ If a student communicates an actual threat of physical violence against an identifiable victim, or evidences conduct or makes statements indicating imminent danger that the student will use physical violence or other means to cause serious personal injury to self or others, I may be required to disclose information in order to take protective actions. These actions may include notifying correctional staff, the potential victim, contacting the police, or seeking hospitalization for the student. I am also obligated to take action if aware of threats to the orderly operation of the facility, such as, but not limited to: escape planning, destruction of property, hunger strikes, drug sale or trafficking during incarceration, inappropriate relationships with staff or other students.

Notably, report of such may result in loss of privileges or liberty.

______ If a student communicates an imminent threat of serious physical harm to him/herself, I may be required to disclose information in order to take protective actions. These actions may include initiating the least restrictive level of security watch necessary to provide protection within the facility or hospitalization.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

______ For many problems and concerns, group settings are the best treatment or intervention. However, while mental health staff instructs all group members to follow the instruction to keep anything said during group to themselves, we cannot guarantee that information discussed during group counseling will not be shared by group members with others. Students found to be sharing information from the group with others may be removed from the group.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

To ensure that the student understands rights to and limits of confidentiality, please review examples of information that is:

A) Completely confidential (e.g., nothing, as the Superintendent can access the health record anytime).
B) Partially confidential (e.g., staff persons, such as a janitor or librarian, who do not have a need in the course of their assigned duties to use mental health information found in the HR).
C) Not at all confidential (e.g., comments in group and threats to self/others).

I have read the above information and have been given the opportunity to ask questions about the limits of confidentiality.

Signature of student	Date signed *(month, day, year)*
Signature of mental health staff member	Date signed *(month, day, year)*

PATIENT IDENTIFICATION		
Full name of patient	Number	Date of birth *(month, day, year)*

CONSENT FOR TREATMENT AND LIMITS OF CONFIDENTIALITY

State Form 48429 (R / 6-12)
DEPARTMENT OF CORRECTION

CONFIDENTIAL

MENTAL HEALTH SERVICES
CONSENT FOR TREATMENT
and
LIMITS OF CONFIDENTIALITY
Understanding and Agreement

Mental Health Services staff provide counseling and psychological evaluations for offenders in this facility. The mental health staff wants you to feel comfortable in discussing your personal concerns with them, but you need to be aware of special situations in which confidentiality will be limited.

Security and safety are very important in jails and prisons. To ensure the safety of everyone, mental health staff must report situations which could be harmful to yourself or others, or a threat to the orderly operation of the facility, such as, but not limited to:

1. Escape planning
2. Planned violence toward others
3. Risk of suicide
4. Hunger strikes
5. Drug sale or trafficking during incarceration
6. Inappropriate relationships with staff
7. Child abuse or neglect
8. Behavior that endangers another person

For many problems and concerns, group settings are the best mode of treatment or intervention. However, while mental health staff encourage all group members to follow the instruction to keep anything said during group sessions to themselves, we cannot guarantee that information discussed during group counseling will not be shared by group members with others. You need to be aware that confidentiality leaks can happen. Offenders found to sharing information from the group with others may be removed from the group.

Progress notes regarding your attendance, level of participation, and treatment progress will be entered into your health record. This information will be released under the same conditions as any other health care treatment information.

I have read the information above and have been given the opportunity to ask questions about the limits of confidentiality. Having understood and agree to the above, I hereby apply for mental health treatment.

Signature of offender / student	Printed name	Date (*month, day, year*)
Signature of staff and title	Printed name	Date (*month, day, year*)
Signature ~~of Superintendent~~ (*juveniles only*) * Guardian *	Facility	Date (*month, day, year*)

PATIENT IDENTIFICATION	
Full name	
Number	
Date of birth (*month, day, year*)	Lock:

CONSENT FOR TREATMENT WITH PSYCHOTHERAPY - JUVENILE

State Form 54395 (8-10)
DEPARTMENT OF CORRECTION / MENTAL HEALTH SERVICES

CONFIDENTIAL

This consent contains important information about your proposed treatment. The law requires that I obtain your guardian/Superintendent's signature acknowledging that I have provided him/her with this information prior to beginning treatment. I also wish to seek your agreement on the terms of our work together. It is very important that you read them carefully so that we can discuss any questions or concerns.

When you sign this document, it will verify that you have received the consent form, understand its content, and agree to treatment. It will also represent an agreement between us and you may revoke this agreement in writing at any time by completing a Refusal form.

PSYCHOLOGICAL THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the mental health professional and student, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during and between our sessions.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time and energy, so you should be careful about deciding to participate. If you have questions about my procedures, we should discuss them whenever they arise.

During the evaluation, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session at a time and frequency we agree on. Typically at the beginning of treatment frequency will be weekly or biweekly depending on your current situation. Frequency of sessions may change during the course of your treatment as we periodically review your progress. **Once an appointment is scheduled, you will be expected to attend unless there are facility circumstances that restrict movement, such as a lockdown or Segregation placement. Should you otherwise decide not to attend, you will be called out to sign a Refusal form in front of me.** I will make every attempt to provide you of advance notice of my cancellation.

CONTACTING ME

My daily work schedule is demanding, so you are encouraged to limit your contact with me to our regularly scheduled sessions. However, if you think that your issue or concern is urgent or emergent in nature, such as wanting to harm yourself or others, please notify the nearest staff person. If your complaint is of a non-urgent nature, please submit a Request For Health Care form to Mental Health. I normally do not answer the phone when I am with a student, so your parent/caretaker in the community is encouraged to leave me a voice mail message. With permission of your guardian/Superintendent, I will make every effort to return his/her call on the same business day he/she makes it, with the exception of holidays.

PROFESSIONAL RECORDS

You should be aware that I keep Protected Health Information about you in the medical record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone.

In addition, I also keep Psychotherapy Notes. These notes are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from student to student, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me. They also may include information from others provided to me confidentially.

Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your medical record, if you request it in writing to your assigned Psychiatric Social Service Specialist. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence. In most circumstance, the State will charge you a copying fee per page.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Printed name of student	DOC number
Signature of student	Date signed *(month, day, year)*
Signature of therapist	Date signed *(month, day, year)*
Signature of superintendent / legal guardian	Date signed *(month, day, year)*

CONSENT FOR TREATMENT WITH MEDICATION

CONFIDENTIAL

State Form 46321 (R4 / 8-10)
DEPARTMENT OF CORRECTION / MENTAL HEALTH SERVICES

I, ________________________________, am a patient of Dr. ________________________________.

My physician / psychiatric provider has informed me that he / she recommends that I receive the medication

________________________________ for ________________________________.
Generic or trade name of medication / dosage range — *Diagnosis*

________ He / she has informed me of the nature of the treatment and has explained to me the risks and possible side effects, including

____.

________ He / she has specifically discussed with me the risk of tardive dyskinesia, which may cause involuntary tic-like movements in the face, tongue, neck, arms and / or legs, and which may persist even after treatment with the medication has been stopped.

________ I understand that although my doctor / psychiatric provider has explained to me the most common side effects of this treatment, there may be other side effects, and that I should promptly inform him / her or another member of the staff if there are any unexpected changes in my condition.

________ I understand that I may discontinue this medication if I choose, but that I should inform my doctor / psychiatric provider before doing so. I also understand that although my doctor / psychiatric provider believes that this medication will help me, there is no guarantee as to the results that may be expected. I have been informed of the risks of refusing the recommended treatment. I have been informed that refusing medication does not prevent me from receiving other types of treatment offered here.

________ On this basis, I authorize my doctor / psychiatric provider or anyone authorized by him / her to administer the above-named medication at such intervals as he / she deems advisable.

Signature of doctor / psychiatric provider	Date signed *(month, day, year)*
Signature of patient	Date signed *(month, day, year)*
Signature of guardian / superintendent or witness (adult facilities)	Date signed *(month, day, year)*

I have been advised to take the medication(s) listed above but I am unwilling to take the medication as recommended.

The possible consequences of not taking the medication have been explained to me. Specifically: ________________________________

____

____

Signature of doctor / psychiatric provider	Date signed *(month, day, year)*
Signature of patient	Date signed *(month, day, year)*
Signature of guardian / superintendent or witness (adult facilities)	Date signed *(month, day, year)*

PATIENT IDENTIFICATION		
Full name of patient	Number	Date of birth *(month, day, year)*