Office of the Chief Psychiatrist and Mental Health Policy

Standard: Compliance is Mandatory

Patient and Solicitor Access to Patient Records

Objective file number: 2011-03602
Standard developed by: Office of the Chief Psychiatrist
Approved by the Minister on: 15 August 2012
Next review due: 15 August 2014

This standard is issued by the Chief Psychiatrist pursuant to s90 of the *Mental Health Act 2009*, which relevantly provides that:

(2) The Chief Psychiatrist may, with the approval of the Minister, issue standards that are to be observed in the care or treatment of patients.
(3) Any standards issued by the Chief Psychiatrist under this section will be-
(a) binding on any hospital that is an incorporated hospital under the Health Care Act 2008*; and*
(b) binding as a condition of the licence in force in respect of any private hospital premises under Part 10 of the Health Care Act 2008*.*

Summary A standard setting out the procedure to be followed by SA Health staff for patient and solicitor access to patient records for the purpose of preparing for an appeal against an Order under the *Mental Health Act 2009*, or an Order under the *Guardianship and Administration Act 1993*.

Keywords Patient and solicitor access, solicitor access, patient access, patient records, records, patient consent, standard

Standard history Is this a new standard? **Yes**
Does this standard amend or update an existing standard? **No**
Does this standard replace an existing standard? **No**

Applies to Inpatient, intermediate care, community recovery centre and community mental health service settings.

Staff impact Moderate. Workplaces and individual staff must alter their existing practices and arrangements for patient and solicitor access to records.

PDS reference D0305

Version control and change history

Version	Date from	Date to	Amendment
1.0	15/08/2012	current	Original version

Government of South Australia
SA Health

PATIENT AND SOLICITOR ACCESS TO RECORDS

1. Standard

Persons experiencing mental illness may be subject to an Order under the *Mental Health Act 2009* (MH Act) or the *Guardianship and Administration Act 1993* (GA Act) to ensure that their health and safety is protected. Orders can require involuntary treatment of a person either within the community or as an inpatient.

Part 11 Division 2 of the MH Act and Part 6 Division 2 of the GA Act provide any person on an Order with the right to appeal the Order:

- Appeals against an Order made by a health professional are made to the Guardianship Board of South Australia (GSB).
- Appeals against an Order or decision made by the GSB are made to the Administrative and Disciplinary Division of the District Court.
- An Order or decision of the District Court may be appealed further to the Supreme Court.

Both Acts provide that any person to whom appeal proceedings relate is entitled to be represented by counsel. However, if a person chooses, they may also represent themselves or be represented by the Public Advocate or other person.

This standard sets out the framework within which patients and solicitors may access a patient's records in order to adequately prepare for appeal proceedings.

For the purpose of this standard:

- The term 'proceeding' refers to a proceeding in respect of an Order made under the MH Act or the GA Act relating to a current mental health consumer with an open episode of care.
- The term 'records' refers to both inpatient and community services records, as reasonably required. It does not include private practitioner records.
- Preparation may be for proceedings to be heard by the Guardianship Board of South Australia, or the District or Supreme Court of South Australia.

This Standard only applies to voluntary and involuntary mental health consumers with a current open episode of care, or those mental health consumers who had an episode of care when a MH Act or GA Act Order was made or in force.

2. Background

Part 11 Division 2 of the MH Act and Part 6 Division 2 of the GA Act both deal with appeals. Both Acts provide for patients (*or the Public Advocate, a guardian, medical agent, relative, carer or friend of the person to whom the Order applies, or any other person who satisfies the Guardianship Board that he or she has a proper interest in the matter*) to appeal an Order made to the GSB.

The GA Act establishes the GSB.

The GSB has express powers to inspect any books, papers or documents and retain them for a reasonable period of time, for the purpose of preparing for a proceeding before the Board.

Historically, patients and their solicitors have experienced inequitable or inadequate access to information regarding their proceeding compared to that of the GSB or court presiding over it.

The procedure set out in this Standard is designed to ensure that patients, and solicitors acting on their behalf, experience equal access to documentation being provided to the GSB, or court, regarding their proceeding.

3. Procedure for Represented Patients

3.1 Accessing Information

In Order to facilitate a patient's and/or solicitor's adequate preparation for a proceeding, the solicitor and patient must be granted access to the patient's records. Access to the records will be provided in a confidential space and be accessed by either the solicitor independently, or both the solicitor and patient. This access will be conditional on:

a. The patient giving written consent for the solicitor to view their records on the consent form provided as Attachment Two of this Standard. If written consent can not be obtained for whatever reason, verbal consent is sufficient and will be clearly documented by the treating team in the record at the time; and

b. The treating team and solicitor having had adequate opportunity to discuss any content within the record that should not be disclosed to the patient that could:

    1. have a substantial adverse effect on the health or safety of the patient, or any other person; and or

    2. reveal personal information about an individual, not including the patient; and

c. An 'Undertaking not to Divulge Requested Information' form having been agreed to and signed by both the treating team and the solicitor, if acting.

3.2 Responsibilities of the Patient

It is the responsibility of the patient (taking into account their mental state) to communicate their consent for the solicitor to access their records for the purpose of adequately preparing for a proceeding.

3.3 Responsibilities of the Solicitor

It is the responsibility of the solicitor representing a patient in a proceeding who is seeking access to records to:

a. obtain the patient's written or verbal consent to access their records, if not already facilitated by the treating staff; and

b. engage with the treating team for the purpose of identifying any information contained within the record that must not be disclosed to the patient; and

c. ensure an 'Undertaking not to Divulge Requested Information' form has been completed and signed by the solicitor and a member of the treating team prior to accessing the record.

Records are not to be photocopied or taken off site.

3.4 Responsibilities of the Treating Team

It is the responsibility of clinical staff involved in the care, treatment and management of the patient to:

a. where applicable, facilitate the patient's written or verbal consent for the solicitor to access their records;

b. ensure adequate care has been taken in reviewing the records, prior to the attendance of the solicitor if adequate notice has been provided by the solicitor, to identify any information that should not be disclosed to the patient (this information must meet the criteria set out in 3.1 (b) of this Standard);

c. communicate clearly and effectively with the solicitor to ensure the solicitor is aware of any information contained within the records that must not be shared with the patient in accordance with 3.1(b) of this Standard;

d. ensure information that is identified as not to be disclosed to the patient by the solicitor, is not used as evidence by the treating team at a hearing;

e. ensure an 'Undertaking not to Divulge Requested Information' form has been completed and signed by the solicitor and a member of the treating team prior to the solicitor accessing the records if applicable; and

f. facilitate access to a confidential setting for the solicitor to access the records either independently or with the patient.

4. Procedure for Patients Self Representing

4.1 A patient subject to a proceeding regarding an Order within the scope of this Standard can choose to represent themself at a proceeding relating to that Order.

Patient's who choose to self represent will have equal access to documentation being provided to the GSB or court regarding their proceeding.

In Order to facilitate the patient's adequate preparation, the patient may have access to their records as set out in 4.2 of this Standard below.

4.2 Access to Information

A patient must be granted access to their records in order to facilitate adequate preparation for a proceeding. The access to the records will be

provided in a confidential space and facilitated at all times by a member of the treating team. This access will be conditional on:

a. a member of the treating team having adequate opportunity to review the records so as to identify any information that should not be disclosed to the patient; and

b. a member of the treating team facilitating the patient's access to the records in a way that will ensure information is not disclosed:

    1. when it could have a substantial adverse effect on the health or safety of the patient, or any other person; and or

    2. when it could reveal personal information about an individual, not including the patient.

c. the patient may make notes as required.

5. Attachments

5.1 *Undertaking not to Divulge Requested Information (MR82R)* Form

5.2 *Patient Consent for Solicitor to View Records (MR82Q)* Form

UNDERTAKING NOT TO DIVULGE REQUESTED INFORMATION

(MR82R)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Patient and Solicitor Access to Patient Records
Mental Health Act 2009—s90 Standard

1. PATIENT DEMOGRAPHIC DETAILS

Address:.....

Suburb:..... Postcode: ____ ____ ____ ____

Telephone: (.....) .....

2. UNDERTAKING NOT TO DIVULGE

I _____ *(solicitors name)* agree not to divulge any information contained within the above named client's records which has been indicated should not be disclosed by his/her treating team.

I understand that the information that has been requested not to be divulged to my client will not be used as evidence by the treating team at the hearing.

3. DETAILS OF SOLICITOR

Full name *(Please print)*:	Designation *(Please print)*:	
Signature	Date ___ ___ / ___ ___ / 2 0 ___ ___	Time ___ ___:___ ___ am pm
Firm/agency *(Please print)*:		

4. DETAILS OF TREATING TEAM MEMBER

Full name *(Please print)*:	Designation *(Please print)*:	
Signature	Date ___ ___ / ___ ___ / 2 0 ___ ___	Time ___ ___:___ ___ am pm
Health service/agency *(Please print)*:		

A COPY OF THIS DOCUMENT IS TO BE PROVIDED TO THE SOLICITOR AND THE ORIGINAL IS TO BE KEPT IN THE PATIENT'S MEDICAL RECORD.

Please use black ballpoint pen when completing this form

Patient Consent for Solicitor to View Records to Prepare for a Proceeding Related to a Mental Health Order

(MR82Q)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Patient and Solicitor Access to Patient Records
Mental Health Act 2009—s90 Standard

1. PATIENT DEMOGRAPHIC DETAILS

Address:.....

Suburb:..... Postcode: ____ ____ ____ ____

Telephone: (.....) .....

2. PATIENT CONSENT FOR SOLICITOR ACCESS

I, the above named, give permission for _____ *(solicitor's name)* of _____ *(solicitor's firm)* to view my records for the purpose of preparing for my proceeding relating to my Order as is consistent with the Patient and Solicitor Access to Patient Records Standard issued by the Chief Psychiatrist under s 90 of the *Mental Health Act 2009*.

Full name (*Please print*):	Self ☐ Medical Agent ☐ Guardian ☐ Parent ☐
Signature	Dat ___ ___ / ___ ___ / 2 0 ___ ___
	Time ___ ___:___ ___ am pm

3. DETAILS OF TREATING TEAM MEMBER

Full name (*Please print*):	Designation (*Please print*):
Signature	Date ___ ___ / ___ ___ / 2 0 ___ ___
	Time ___ ___:___ ___ am pm
Health service/agency (*Please print*):	

A COPY OF THIS DOCUMENT IS TO BE PROVIDED TO THE SOLICITOR AND THE ORIGINAL IS TO BE KEPT IN THE PATIENT'S MEDICAL RECORD.

Please use black ballpoint pen when completing this form

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