DEPARTMENT OF CORRECTIONS

Policy: 500.307
Title: Mental Health Records
Effective Date: 11/19/18

PURPOSE: To provide guidelines for collection, organization, retention, and disposition of mental health care documentation.

APPLICABILITY: Department-wide

DEFINITIONS: None

PROCEDURES:

A. Record creation

A mental health record is created for each offender/resident at the time of admission to the department.

1. The record folder is divided into nine sections: client data, clinical information, referrals, correspondence (to include all correspondence created or received by providers), legal, staff observations, confidential (information that is confidential by statute and cannot be accessed by the offender), past records, and treatment programs.
   a) Information in each section must be filed in chronological order with the most recent information on top.

   b) Filing guidelines for mental health records, detailing the filing location for various forms, are found at the behavioral health private iShare site.

2. If a record file folder becomes full, another folder is established. All multiple folders must be labeled on the index with the volume number and the inclusive dates (e.g., Vol. 2 5/12/2005 – 8/1/2009).

3. Mental health records are secured in a central location, accessible only to authorized staff.

4. Mental health records are transferred with the offender/resident at the time of facility transfer. If it is not possible to transfer the record with the offender/resident, it must be sent to the receiving facility without delay.

5. Record retention
   a) When an adult offender is released, the offender's mental health record is archived at central office.

   b) When a juvenile resident is released, the mental health record is archived at the releasing facility.

   c) Archived records are retained and eventually destroyed, as specified in Policy 106.220, "Offender/Resident Case Records."

6. Providers must release information from the mental health record according to Policy 106.210, "Providing Access to and Protecting Government Data." and Policy 500.3071, "Behavioral Health Data Practices."

7. Behavioral health services supervisory staff perform annual documentation audits, which are maintained in the supervisor's file and discussed with the employee. A minimum of ten mental health files are reviewed by the mental health director at each facility during each quarter. Compliance is noted in the quarterly report.

B. Record format

1. Providers document clinical entries in the following format, referred to as "SOAP":
   a) Subjective – offender/resident statements, presenting complaints.
   b) Objective – provider's observations, objective findings, interventions provided.
   c) Assessment – findings including impressions, diagnosis, improvement, deterioration, and case conceptualization.
   d) Plans – provider's goals, referrals, orders, plans for treatment and case management.

   Providers may document group therapy, incidental encounters, and behavioral observations in appropriate alternative formats.

2. Mental health entries having implications for medical care, including all psychiatric entries, are sent to the offender's/resident's medical record.

3. The author must authenticate all record entries with the author's signature and professional designation.

4. Providers must write or dictate all record entries without delay. Entries that are retrospective or unavoidably delayed must be labeled ("Late Entry" or "LE") with the date of the event and date of the record entry.

5. Providers must sign dictated reports as soon as possible after transcription. If the provider is not able to review and sign a dictated report, it must be filed with the legend "dictated, but not reviewed" on the signature line.

6. Only the author of a record entry may change it, by making corrections with a single line through the text, and initialing and dating changes. An entry must not be corrected if it was accurate at the time it was written; instead, a new entry should be made explaining any new information or changed situation.

7. All entries must be legible and in ink.

8. Record entries must not use abbreviations unless they are in common professional use.

9. If possible, providers should avoid making references in the record to other identifiable offenders/residents.

INTERNAL CONTROLS:

A. All record entries are authenticated with the author's signature and professional designation.

B. Mental health records are secured in a central location, accessible only to authorized staff. Mental health entries having implications for medical care, including all psychiatric entries, are sent to the offender's/resident's medical record.

C. Mental health records for released offenders/residents are archived in central office for adult males, and at the releasing facility for juveniles and females.

ACA STANDARDS: 4-4413, 4-4396, 4-4414, 1-ABC-4E-52, 1-ABC-4E-53, 1-ABC-4E-54

REFERENCES: Policy 106.210, "Providing Access to and Protecting Government Data"
Policy 106.220, "Offender/Resident Case Records"
Policy 500.3071, "Behavioral Health Data Practices"
Minn. Stat. §§ 148.965 (Test Security); 244.03; 241.021, subd 4; and 148E.230 (Confidentiality and Records – re social workers)
Minn. Rules 2150.7535 (Board of Behavioral Health and Therapy – Record Keeping)

REPLACES: Policy 500.307, "Mental Health Records," 2/20/18.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: None

APPROVED BY:
Deputy Commissioner, Facility Services
Deputy Commissioner, Community Services
Assistant Commissioner, Facility Services
Assistant Commissioner, Operations Support