

THEIMANN

ADVISORY

School of Social Work
University of North Carolina at Chapel Hill



Tina Souders, MSW, JD
Kim Strom-Gottfried, PhD, LISW
David DeVito, MSW
Premela Deck, MSW, JD

November 2016

FAQ on Documentation and Clinical Records

Introduction

Theimann Advisories are periodic commentaries on the ethical, legal, and clinical implications of complex service dilemmas. They are issued with the support of the Smith P. Theimann, Jr. Distinguished Professorship in Ethics and Professional Practice and are distributed to alumni, students, and field instructors affiliated with the UNC Chapel Hill School of Social Work, as well as to the broader community of service providers.

Advisories use laws, ethics, and professional standards to craft recommendations in response to specific practice questions. They are intended to provide general guidelines for practice, but are not a substitute for legal advice or professional consultation and supervision on specific case matters. This *Advisory* utilizes North Carolina statutes in examining the issues presented. As such, some advice may not translate to other jurisdictions. Changes in laws, regulations and practice guidelines that occur after the *Advisory* is issued may also affect the relevance of the recommendations.

This *Advisory* addresses the challenges surrounding clinical documentation in health, mental health, education, substance abuse, child welfare and other service settings. This includes services to individuals, groups and families, but does not include billing and financial records, personnel records, meeting minutes, research findings, or other organizational documents. The *Advisory* is intended to apply to the array of helping professionals including social workers, counselors, and psychologists in a variety of settings, though any meaningful distinctions among settings or types of professionals will be noted in the document.

Relevant Definitions

HIPAA: The Health Insurance Portability and Accountability Act of 1996 was enacted to protect private health information, facilitate the exchange of health information between patients, providers, and ancillary agencies involved in health care finance (e.g., clearinghouses and insurance agencies) (US Department of Health and Human Services [USDHHS], 2003), and to grant patients the right to view their medical records on request (Ross & Lin, 2003). The **Privacy Rule** is borne out of this legislation (USDHHS, 2003) and contains the majority of the stipulations that are encompassed by HIPAA.

The Privacy Rule covers health plans, health care providers, health care clearinghouses, and business associates (consultants) working with these organizations (USDHHS, 2003). Individually identifiable protected health information (PHI) may not be disclosed (in most instances) by a covered entity (CE) without the consent of the patient (USDHHS, 2003). Exceptions include disclosures that are necessary for payment, treatment, and healthcare operations (e.g., quality control), to address situations when the public's interest is at stake, and for research purposes with the caveat that the records be de-identified (which is to say that all personal and demographic information is removed from the shared records) (USDHHS, 2003). HIPAA also mandates certain privacy practices that covered entities must follow such as providing patients with a **notice of privacy practices (NPP)**. The expectations for NPP are stringent, and providers must note that client consent for NPP is not the same as consent to treatment, testing, research, or other arrangements addressed at the outset of service (Zuckerman, 2008). The **Security Rule** delineates procedures needed to safeguard protected health information (such as locks and encryption for storage and transmission of client data) (Kagle & Kopels, 2008).

Progress notes (“treatment notes” or “clinician notes”): These documents are service-specific and pertain to a particular provider, discipline, or service program. Treatment notes entail the full scope and process of services from intake and assessment, goal definition, and treatment planning, to intervention and evaluation, discharge or termination, and follow-up care. The detail and emphasis of documentation in any area depends on the length of time that the client engages in treatment (Kagle, 1984) and the nature of the services provided. These notes are typically part of the client's formal case record or medical record.

Medical records: North Carolina General Statute §90-410(2) Article 29 defines a medical record as “personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, excluding X rays and fetal monitor records.” This includes service documentation, medical history, test and lab results, surgical history, and patient demographics. The content and availability of medical records which have been recorded on paper and by hand are typically determined by the particular office generating them. For example, dental records are generally not included in the patient's medical record stored at his/her physician's office, except in those cases when the patient has requested for them to be shared with the physician.

More commonly, paper records are being supplanted by electronic versions, which vary in terms of content and access. Electronic medical records (EMR) are created, maintained, and accessed within a given agency (USDHHS Office of the National Coordinator for Health Information Technology, 2008). Hospitals and other organizations must develop policies about how EMR can be accessed by an array of personnel and clients should be informed of this at time of consent.

EMR offer increased efficiency and ease for providers, as information can be accessed instantly from a number of locations within and outside the facility's walls. The resulting proliferation of private health information also represents an increased risk for misuse, theft, or inadvertent alteration of records. The provisions laid out in the Security Rule are designed to allow for covered entities to make use of electronic medical records while also keeping patient's health and demographic information private as intended by the Privacy Rule

Psychotherapy notes: These are “notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.” (DHHS, 2007, §164.501). As such, psychotherapy notes might contain clinical hunches, themes, excerpts of dialogue, and/or particularly sensitive information about the client's life. HIPAA gives special consideration and protections to these notes: psychotherapy notes must be kept separate from the patient's medical record, there is no right of client access, and they are not routinely discoverable in legal actions as progress notes would be (Zuckerman, 2008). However, exceedingly cautious practitioners would limit what they write in these notes due to the risk of subpoena, however slight.

Electronic communications: Correspondence via e-mail, FAX transmission, text-messaging, and telephone calls are all electronic communications. Providers should have policies about their availability via these forms of contact and tell clients about these policies during informed consent. Information sent or received through these media should be recorded or included in the client record.

While HIPAA legislation defines covered entities as those that engage in electronic transmission of private health information, clinicians who only keep paper records must also be mindful of how third-party payers handle storage and

transmission of their clients' PHI. Providers who share PHI with an entity that transmits or stores information electronically are considered covered entities under HIPAA legislation, and are required to comply with all of the provisions set forth by the Privacy and Security Rules.

Frequently Asked Questions

1. *Why do documentation? Is it for the agency or the client?*

Reamer (2005) proposes six functions of documentation: assessment and planning, service delivery, continuity and coordination of services, supervision, service evaluation, and accountability. Thus the audience for documentation in clinical practice includes: the treating professional, supervisors, quality assurance personnel and program evaluators, other treating clinicians (with the patient's authorization), utilization review personnel, officers of the courts, and clients/patients and their caregivers or guardians. Records, reports, case notes and other written products and forms address the ethical, legal, financial and clinical dimensions of service: they hold the professional accountable and provide evidence to support claims about the quality and course of treatment (Wiger, 2009; Zuckerman, 2008).

The National Board of Certified Counselors makes an important distinction about the possession of records noting "The physical records are property of the certified counselors or their employers. The information contained in the records belongs to the client and therefore may not be released to others without the consent of the client or when the counselor has exhausted challenges to a court order" (NCBB, 2010). If the court orders the professional to provide information contained in the client record, professionals should reiterate to the court their ethical responsibilities to maintain confidentiality and that it is contrary to professional ethical standards to provide confidential information without client consent. This distinction is similar to that of other professional associations.

2. *How do I document a treatment group to capture the interactions, but avoid revealing individual information?*

Keeping individual notes for group members is a clear-cut approach to documenting therapeutic groups with the intent of upholding the most stringent confidentiality standards. Such notes may be in narrative form or utilize pre-printed forms (see Wiger, 2009 or Zuckerman, 2008). Using individual recording, the other members in the group could be referred to by a single initial or a non-descript pronoun (e.g., "he", "another member"). The latter strategy may sacrifice the clinical utility of the documentation in favor of privacy, as the clinician may eventually have difficulty recalling the identities of other members and the group processes involved.

Capturing interactions via diagrams, charts, or group summaries can be clinically helpful, (Cox, 1978; Yalom, 1995) though it does not afford the same assurances of participant privacy, in that all group members information would be revealed should any one member's information be disclosed (Reamer, 2005).

The National Association of Social Workers Code of Ethics (2008) instructs clinicians who work with groups to inform group members about the type of recording procedures that will be followed and to discuss the limitations and assurances of confidentiality imposed by the chosen system.

3. *If I see a family, does each member have his or her own record? Is there just one record? Who can see it?*

As part of the informed consent discussion at the outset of treatment, the rules and expectations of the professional and clients should be explicitly addressed. This should include how individual information or secrets should be handled, how members who are absent from sessions will be informed about what takes place in their absence, etc. Central to this conversation is the nature of the records that will be kept and the access of members to those records. A single (common) record has the advantage of capturing family processes and interactions. The primary disadvantage is that it refers to, and thus is available to, all members of the family/client system.

Moline, Williams, and Austin (1998) recommend that clinicians ask themselves two questions with regard to keeping common records for family members who are seen together: “Would I want all members of the family or couple to be reading what I am writing?” and “Can I predict what will happen to these records?” (p.59). A variation asks “Would all family members be comfortable having others members read what is written?” If the answer to any of these questions is “no,” then separate records should be kept because a single record could be requested by any of the family members or subpoenaed as a whole by the courts. The NASW Code of Ethics reminds social workers to protect the confidentiality of others including family members who are identified or discussed in the client record. (1.08b)

Reamer (2005) notes that as is the case with group work, maintaining individual notes preserves confidentiality under a wide range of circumstances, while group notes honor the interactional approach of conjoint therapy and are therefore clinically superior. A third and most cautious option would be a hybrid that entails keeping a general group/family record as well as individualized records for sensitive or potentially compromising (yet relevant) information.

4. *How long do I have to keep records?*

The NASW Code of Ethics (2008) calls for social workers to keep records according to the mandates set by state statutes and relevant contracts [Section 3.04 (d)]. The NBCC Code stipulates that “Records should be maintained for a period of at least five (5) years after the last counselor/client contact, including cases in which the client is deceased” (2005, B5). APA Record Keeping Guidelines (2007) recommend (in most cases) retention for 7 years after the end date of last contact for adult clients and 3 years after a minor client reaches the age of majority.

North Carolina state statutes do not specify a length of time that health care professionals must maintain records (North Carolina Medical Board, 1998). Insurance companies and other payers contracting for services may set forth requirements for maintaining records. (The NC DHHS Office of the Controller issues a record retention policy and an annually updated spreadsheet regarding record disposal <http://www.ncdhhs.gov/control/retention/recordsheet11.pdf>). In the absence of legal or contractual obligations, practitioners are free to set their own guidelines. HIPAA has established a minimum threshold of “six years for retention of PHI” (Zuckerman, 2008, p. 34) after the conclusion of treatment. Internal Revenue Service rules require maintenance of financial data for seven years.

In the absence of contractual or regulatory standards, the clinician must balance the pros and cons of record retention in crafting a personal policy on the matter. The predominant advantage of keeping records indefinitely or for a protracted period of time (over fifteen years post-termination) is that they are available should questions ever arise about the nature and quality of care delivered. A consideration in this decision is the statute of limitations on malpractice suits in a given state (Kopel and Kagel, 2008; Moline, Williams, and Austin, 1998). In North Carolina, this is between 3 and 4 years after the last act of the practitioner, as an allowance is made for injuries discovered some time after the termination of care (N.C. Gen. Stat. §1-15). The statute of limitations on malpractice suits relating to service to minors is the same time frame or until the minor reaches age 19, whichever is longer.

Kagel and Kopel (2008) suggest that clinicians keep records for the longest statute of limitation period defined by the state (10 years in North Carolina) (N. C. Gen. Stat. §1-56), as attorneys may pursue lawsuits based on infractions other than medical malpractice. Zuckerman (2008) suggests that clinicians keep records for 15 years (unless required to keep them longer by state law). Due to the breadth of possible legal contingencies, the National Association of Social Workers Insurance Trust recommends that members keep their client records indefinitely (Robb, 2004).

However, there are compelling disadvantages in keeping records forever or for a protracted period of time. One consideration is simply the volume of records accumulated and the measures needed to keep vast records secure yet retrievable if needed. Another problem involves the relevance of dated case material and the risk that dated findings will be misused or misinterpreted to the detriment of the client or the clinician. A final hazard involves the obsolescence of electronic media and software. Given the pace of technological change, can electronic records be read five, ten, or twenty years after service?

A good rule of thumb offered by Zuckerman is to maintain minors’ records for five years after they reach the age of majority and “keep adults’ records for at least 12 years” (2008, p. 35). Whatever timeline is developed, it should be applied

consistently for all cases and incorporated into succession plans in the event of the agency's closure or the practitioner's retirement, incapacitation, death, or retirement. Clients must be informed of the policies about the availability and retention of records at the outset of service.

5. *I am in private practice. How do I give my back-up person access while I am on vacation? What if I die suddenly? What about after I retire?*

Pope and Vasquez (2007) offer important factors to consider when arranging for back-up coverage in the event of a vacation or sudden illness. These items include: guidelines for the back-up provider's availability, protocol for the back-up provider to review the client's case record, clarifying where the back-up provider's documentation will be filed, and procedures for the back-up provider to obtain informed consent from the client. A back-up provider should be selected based on experience, professional reputation, availability, and suitability to respond to the vacationing clinician's caseload (Pope & Vasquez, 2007). Additionally, planned interruptions in service should be announced well in advance, and addressed in session so that the client is able to process the break and understand the terms of back-up service (Pope & Vasquez, 2007). As a practical matter, the back-up's actual access to records can be facilitated by sharing the file access, office keys, passwords etc. needed to make the materials available. Such keys and passwords should be changed when the back-up relationship ceases so that records have continued protection.

According to the NASW Code of Ethics (Standard 1.15) social workers should make allowances for the continuity of services in the event of sudden illness or death. Pope and Vasquez (2007) provide a guide to the important factors of a professional will. These include: identifying the primary designate to assume responsibility for the case load, identifying individuals to serve as back-up in case the primary designee is unable to fulfill the responsibilities, information related to the details of the practice (e.g., the office location, security measures, record depository, client registers, accounting procedures, practice schedule, modes of client contact, information concerning liability insurance), and an established plan for notifying clients and colleagues of the death. Zuckerman (2008) recommends that when a clinician retires s/he should contact the clients for whom she is still retaining records and offer to have them sent to another treating therapist, another health professional, or a storage site for the remainder of the time agreed to in the informed consent process.

6. *A colleague refuses to keep case records because she says they are too much of a liability. True?*

Not true. In fact, *not keeping* records is a liability (Kagel & Kopels, 2008; Moline, Williams, & Austin, 1998; Reamer, 2005; Zuckerman, 2008). Each of the authors cited above notes that clinical records are a basic defense against a malpractice suit. Service documentation will include the informed consent process, a description of the justification and plan for treatment, a record of the clients' level of participation and reaction to treatment, and the details of the termination of treatment. Additionally, many professional codes of ethics (including the American Counseling Association, the American Psychological Association, the American Association for Marriage and Family Therapy, and the National Association of Social Workers) mandate that clinicians keep client records (Moline, Williams, & Austin, 1998). An accurate, contemporary record of quality services is a means to protect clinician liability, not create it.

7. *I got months behind in my recordkeeping for all of my cases. What should I do now?*

This situation should be avoided, as timely recording ensures accurate reporting (Reamer, 2005). Zuckerman (2008) urges clinicians to build in time between appointments to assure that relevant information is captured. At the very least, a "24-hour policy" will assure that all client contacts are documented in a timely manner, though given the pace of service delivery case information may become blurred even in this timeframe.

Should a clinician fall behind in documentation, an attempt must be made to record the services provided in a faithful and accurate manner. Ostensibly, the details of the service will be sacrificed, as it is important to preference accuracy over breadth of information. In short, attempt to catch up; but, do not include details that you are not certain about. Use accurate dates to indicate when the services were provided and when the records were created. Do not attempt to "back-date" files.

8. How much is too much to include in session documentation?

In general, unconfirmed reports about a third party by the client, the personal judgments, opinions, or clinical hypotheses of the clinician, and sensitive information that is not relevant to treatment should be omitted from service documentation (Kagle & Kopels, 2008; Reamer, 2005; Moline, Williams, & Austin, 1998; Zuckerman, 2008). Further, a client's past criminal behavior (Moline, Williams, & Austin, 1998; Zuckerman 2008), and the inadequacies of other service providers (Reamer, 2005; Zuckerman, 2008) should also be left out of the client record. When describing the essential qualities of good documentation, Kagle & Kopels (2008) include "abridgement" as a guiding principle, indicating that the "records include no more information about the client-need-situation than is pertinent to the purpose, goals, and outcomes of service" (p. 10).

9. A client had an erection during our entire session yesterday. Should I mention it in the charts?

The guidance offered in question #8 is relevant here. Most of the content of a therapy session is sensitive and personal, and may be embarrassing to clients if shared with others. Therefore, include only those items that are pertinent to, and have bearing on, the goals and direction of treatment. In this case, two factors seem pertinent to that determination: 1) is this condition at all relevant to the issues in treatment? and 2) did the therapist mention the client's erection in session? For example, if the client is concerned about becoming aroused at inopportune times and the instance in the session is an example of this, then the erection would be an appropriate detail to include in the clinician's record of the session. On the other hand, if this is a first-time occurrence which had little to do with the reasons that client is in treatment and was not addressed by the clinician it should be left out of the documentation of this session. This is not to say that the clinician forgets the detail altogether; he or she might indicate it in his or her psychotherapy notes for future reference. Should the erection in session happen repeatedly, it would be constructive for the clinician to acknowledge the situation, and explore the client's reactions and the meaning he ascribes to it. This exchange would likely then be recorded in the session documentation without judgment and with sensitivity to the client's self-esteem and privacy.

10. I have just started seeing a client and have several hypotheses about why he is behaving a certain way (leading to trouble in his workplace). Should I document my hunches or wait until one is more confirmed than the others?

As mentioned in the response to question #8, hunches and theories should not be included in the client record. Progress notes should be based on the observations and facts from the clinical encounter (Moline, Williams, & Austin, 1998). Clinicians should only include in the clinical record those items of which they are assured and that have implications for treatment (Kagle and Kopel, 2008). An exception to this guideline would be an instance when a therapist shares a hunch or hypothesis with the client. The documentation of this exchange would then be factual and include a description of the client's reaction to the clinician's theory. The proper place for hypotheses and other musings would be in the clinician's psychotherapy notes, maintained separately from the clinical record.

11. When a client discloses past crimes (robbery, assault) or bad acts (killing animals) or fantasies (sexual fetishes) I usually deal with them in the context of whatever the presenting problem is, but I feel uncomfortable explicitly recording them.

The advice offered in the answers to questions 8, 9 and 10 applies here as well. Past crimes and sensitive information that may be potentially embarrassing or damaging to the client should not be included in the service record unless it is deemed to be relevant to the client's treatment. In those instances when it is determined that this information has bearing on the case, the clinician can make a general statement without disclosing the potentially damaging details of the client's life. For example, rather than stating "client tortured the family cat on four occasions using a tire iron, ultimately killing it and burying it in the woods near his home" one could say "client reported past cruelty to family pet." The latter note does not reveal the timing, extent, duration, nature or outcome of the cruelty, nor the type of animal involved.

12. I work on an interdisciplinary team and we all have access to the record. Clients may share things with individual members without knowing that others on the team can see them. For example, they may tell the dietician that they are "cheating" on the food plan, which would throw their meds off. Other times, they just share personal information that is not so relevant to the team, but I feel bad withholding it.

Clients should have knowledge of everyone who views and contributes to their records. Whether the team operates under the auspices of one organization or several, the HIPAA Privacy Rule allows for the disclosure of information for the purposes of treatment (USDHHS, 2003). As it is a regular occurrence for multiple providers to access a client's full record in the example above, this should be noted in the informed consent process and then included in each of the agency's notices of privacy practices.

Regarding the patient who "cheats" on his/her food plan, the clinician should judge the magnitude of risk that the behavior poses, and present the client with the option of discussing the eating behaviors with the prescribing physician. If the client refuses, and the clinician has determined that the risk is so great as to pose potentially irreversible harm to the client, then the clinician should offer to make the disclosure on behalf of the client. This exchange may take several different directions from this point, but what remains constant is the clinician's focus on the client's safety and wellbeing.

13. *If the client signs a release, must I share records, even if I feel the client has not appreciated the repercussions of signing a release? Must I share everything? For example, a client who is easily coerced by his parents has given permission for them to see the records, but a focus of our work involves questions about his sexual orientation.*

In general, clients who have signed a release should have reasonable access to their records unless social workers are concerned that information contained in the record may be harmful to the client. Limiting access to portions of records that may be detrimental to the therapeutic process and it may thus be necessary to assist clients in interpreting distressing or confusing material. (NASW Code 1.08).

An especially difficult task of any clinician is balancing the rights of minor clients and parents in the treatment milieu. Access to a child's records is a parental right and generally is not problematic unless the interests of the minor client conflict with those of his/her parent. In these circumstances, social workers should consider the child's preference in releasing the information, any legitimate safety concerns, and the likelihood that substantial harm would result from releasing the records (NASW, 2010).

If the client referenced above is an adult, a salient question would be whether the client has the capacity to render consent. Does he/she understand the scope and content of the records and the implications of release? Is he or she consenting voluntarily to release? A review of these issues may lead the client to reconsider the consent to release or may lead the clinician to determine that the client is incapable of rendering informed consent. Clearly the decision to deny the client's request and the underlying rationale should be documented in the case record. A further strategy suggested by Zuckerman is the use of a highly explicit authorization form, which specifies the scope of information to be released and the possible implications of release (2008).

14. *Where should I record material that doesn't go in the case record, such as supervision received or given, consultations, discussions about ethical dilemmas, notes to myself on clinical hunches, etc? Should I keep these or dispose of them? Are they discoverable?*

Many clinicians maintain clinical notes separate from the official medical record or clinical case file. These psychotherapy notes are not required of clinicians but if kept, they are afforded additional privacy protections. Personal notes, which differ from psychotherapy notes, may be kept in a separate file. However professionals should exercise caution when utilizing this form of documentation as these notes may be discoverable in court cases and hence viewed by third parties (Reamer, 2005).

Supervision and consultation are essential to the provision of high-quality professional services. Complex clinical issues and novel ethical dilemmas necessitate discussion with experienced colleagues, supervisors or other knowledgeable professionals. Reamer (2006) notes several key steps in resolving ethical dilemmas including documentation of the consultative process undertaken by the social worker. It is appropriate to document in the clinical record that consultation or supervision was sought on a particular issue to deter a claim that the professional neglected to seek proper assistance. Detailed notes of the consultation should be maintained in a separate file.

15. Can you address the basics of responding to subpoenas and court orders? What's the difference?

A subpoena is a legal mandate that compels an individual to serve as a witness (*subpoena ad testificandum*) and/or compels the production of documents or other things to the court (*subpoena duces tecum*). Subpoenas are part of the discovery process utilized by the courts and attorneys to gather information related to pending litigation or an administrative hearing. Professionals need to weigh ethical and legal obligations in complying with a subpoena while protecting clients' privacy and confidentiality.

NC General Statute §8-53.7, also known as the Social Worker Privilege Statute states, in part, that social workers shall not disclose any information acquired in rendering professional services unless a court compels disclosure. This privilege is asserted by the social worker on behalf of the client. On the other hand, if it is your client's attorney who is seeking the information and the information is about your client, then the client would waive the privilege and the information may be disclosed. Should you have concerns about releasing records under these circumstances, it is best to consult your own attorney.

Social workers should also be familiar with NC General Statute §8-53.6 regarding testifying in divorce and alimony actions. Briefly, it states that licensed social workers who provide marital counseling to individuals or couples seeking a divorce, post-separation support, or an alimony action are not competent to testify in that action. In this case, competency refers to the legal authority to testify not the practitioner's mental capacity.

Upon receiving a subpoena, the clinician should establish whether the scope of the subpoena extends to privileged and/or non-privileged matters. Attorneys have broad discretion in issuing a subpoena and a professional may challenge or object to the subpoena particularly if a response would violate confidentiality. The professional may contact the client who can provide a written consent allowing the worker to speak to the client's attorney. Conversely, a practitioner may object to a subpoena in its entirety or in part. Filing a written objection or a motion to quash the subpoena may be necessary in order to preserve confidentiality and require the court to order the production of documents or testimony.

A court order is an official ruling by a judge that mandates action or compliance (such as the production of certain documents and/or the professional's testimony before the court). The court weighs several factors before compelling disclosure including the client's right to privacy and the right to a fair trial. Failure to obey a subpoena or court order is considered contempt of court and could result in a fine or imprisonment. NASW Code 1.07(j) states that "when a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection." Consequently, clinicians who are compelled to disclose confidential information are not without options and can request that the judge review the material in chambers, close the proceedings from the public, limit the number of copies and distribution of the records, and seek return of the original documents when the proceedings are completed (Barsky & Gould, 2002). When preparing compelled documents for court, clinicians should always take into account the scope of the court order and provide only information that conforms to that order.

16. Should phone and email correspondence with clients be included in their records?

Professionals should refer to agency policies and procedures regarding documentation of phone contact and email correspondence with clients as well as the confidentiality of information transmitted through all electronic media. As new forms of wireless communication evolve, such as texting and social networking, professionals should be aware of the challenges inherent in these new technologies. Issues regarding confidentiality, access, reliability, risk management and technological competence should be addressed at an agency level. The NASW Standards for Technology and Social Work Practice (2005) is a valuable resource for organizations and individual practitioners as these emergent technologies continue to permeate everyday practice. In the absence of agency guidelines, practitioners are advised to restrict electronic communications to basic matters such as appointment reminders, cancellations, etc. If substantive topics are shared electronically, by the worker or the client, those communications should be noted in the client's record.

17. I work for a public agency and we have a very complex, high profile case that is causing me a lot of distress. I would like to see a therapist about my stress but am concerned that the records could be used against me or my agency (or other parties in the case) if there is litigation.

The question is whether or not the information contained in a therapist's records is protected information and thus shielded from court proceedings. This issue is well settled in law and ethics. Professionals have an ethical and legal obligation to protect client confidentiality at all times. Clinical conversations and records are subject to special protections during legal proceedings through the doctrine of privileged communication. "The concept of privilege concerns the admissibility of information in court, especially the extent to which courts may compel disclosure of confidential information during legal proceedings" (Reamer, 2006, p. 68).

In the historic case of *Jaffe v. Redmond* (1996), the US Supreme Court ruled that conversations between a client and psychotherapist are privileged and protected from compelled disclosure in Federal courts. In *Jaffe*, a former police officer sought services from a licensed clinical social worker after a tragic and deadly shooting. In a lawsuit against the police officer, the plaintiff sought access to the private clinical notes of the therapist. The social worker asserted the conversations were protected from disclosure by a psychotherapist-patient privilege and, although the District Court initially rejected this argument, Justice John Paul Stevens, writing for the majority, stated that:

Effective psychotherapy... depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. (*Jaffe v. Redmond*. (1996). 518 U.S. 1; 116 S. Ct. 1923; 135 L. Ed. 2d 337, part III)

The *Jaffe* ruling broadened the scope of the *psychotherapist-patient privilege* in Federal court to include licensed clinical social workers and, in North Carolina, licensed clinical social workers can assert this privilege under N.C. Gen. Stat. § 8-53.7. The statute states, in part, "no person engaged in delivery of ... social work services, duly licensed or certified.... shall be required to disclose any information that he or she may have acquired in rendering professional ... services". North Carolina state statutes also provide a similar privilege for licensed counselors, psychologists, marital and family therapists and school counselors. This privilege is a right that belongs to the client and should be asserted by the practitioner, unless waived by the client. A court may, however, compel disclosure of protected information if the court deems it necessary for the proper administration of justice. Your decision to seek help for your personal wellbeing and to assure your competence as a professional in this complex case is commendable and defensible. The benefits of seeking therapy would seem to outweigh the risks of compelled disclosure and should be supported by your therapist and your professional association if threatened.

Acknowledgements

We are indebted to Hilary Anderson, MSW, Alison Prevost, MSW, Lisa Sinden Gottfried, PhD, and Melissa Grady, PhD, MSW for sharing their time and expertise in reviewing and improving this *Advisory*.

References and Resources

- American Psychological Association. (2007). Record keeping guidelines. *American Psychologist*, 62(9), 993–1004.
- Barsky, A.E. & Gould, J.W. 2002. Clinicians in court: A guide to subpoenas, depositions, testifying, and everything else you need to know. New York, NY: The Guilford Press.
- Cox, M. (1978). *Coding the therapeutic process: Emblems of encounter. A manual for counselors and therapists*. New York: Pergamon Press.
- Jaffe v. Redmond. (1996). 518 U.S. 1, 116 S. Ct. 1923, 135 L. Ed. 2d 337.
- Kagle, J. D. (1984). Restoring the clinical record. *Social Work*, 29, 46-50.
- Kagle, J. D. & Kopels, S. (2008). *Social work records* (3rd ed.). Long Grove, Illinois: Waveland Press.
- Levin, A. M. (1983). *The private practice of psychotherapy*. New York: The Free Press.
- Moline, M. E., Williams, G. T., Austin, K. M. (1998). *Documenting psychotherapy*. Thousand Oaks, CA: Sage.
- National Board of Certified Counselors. (2005) *Code of Ethics*. Retrieved May 22, 2010, from <http://www.nbcc.org/AssetManagerFiles/ethics/nbcc-codeofethics.pdf>.
- NASW & ASWB Standards for Technology and Social Work Practice. (2005). Retrieved July 2, 2010 from <http://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf>
- National Association of Social Workers. (n.d.). *Code of Ethics*. Retrieved June 1, 2009, from <http://www.socialworkers.org/pubs/Code/code.asp>
- National Association of Social Workers. (2010). Children’s treatment records: Parental access and denial. Retrieved July 2, 2010 from http://www.socialworkers.org/ldf/legal_issue/2010/201006.asp
- North Carolina General Statutes. (2009). Retrieved July 2, 2010 from <http://www.ncleg.net/gascripts/statutes/Statutes.asp>
- N.C. Gen. Stat.§ 8-53.3. Communications between psychologist and client or patient
- N.C. Gen. Stat.§ 8-53.4. School counselor privilege
- N.C. Gen. Stat.§ 8-53.5. Communications between licensed marital and family therapist and client(s).
- N.C. Gen. Stat.§ 8-53.7. Social Worker privilege
- N.C. Gen. Stat.§ 8-53.8. Counselor privilege
- North Carolina Medical Board. (1998). *Retention of medical records*. Retrieved June 2, 2009, from http://www.ncmedboard.org/position_statements/detail/retention_of_medical_records/

- Pope, K. S. & Vasquez, M. J. T. (2007). *Ethics in psychotherapy and counseling (3rd ed.)*. San Francisco, CA: John Wiley & Sons, Inc.
- Reamer, F. G. (2005). Documentation in social work: Evolving ethical and risk-management standards. *Social Work, 50*, 325-334.
- Reamer, F.G. (2006). *Social work values and ethics, 3rd edition*. Columbia University Press.
- Robb, M. (2004). *Practice pointers. Client records: Keep or toss?* Retrieved June 4, 2009, from The NASW Insurance Trust Web site: http://www.naswassurance.org/pdf/PP_Record_Retention.pdf
- Ross, S. E. & Lin, C. (2003). The effects of promoting patient access to medical records: A Review. *Journal of the American Medical Informatics Association, 10*, 129-138.
- United States Department of Health and Human Services (2003). *OCR privacy brief: Summary of the HIPPA Privacy Rule*. Retrieved June 1, 2009, from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>
- United States Department of Health and Human Services, (2004). Code of Federal Regulations, Title 45 § 164.501, Definitions
- USDHHS Office of the National Coordinator for Health Information Technology. (2008). *Defining key health information technology terms*. Retrieved June 1, 2009, from http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf
- Wiger, D.E. (2009). *The clinical documentation sourcebook (4th ed.)*. Hoboken, NJ: Wiley.
- Yalom, I. (1995). *The theory and practice of group psychotherapy (4th ed.)*. New York: Basic Books.
- Zuckerman, E. L. (2008). *The Paper Office (4th ed.)*. *The tools to make your psychotherapy practice work ethically, legally and profitably: Forms, guidelines, and resources*. New York: Guilford.