KEEPING TREATMENT RECORDS – HOW MUCH?

written by Richard Leslie | October 1, 2020

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NOTE: ***This article was first published on the CPH Insurance's website approximately eight years ago – in mid 2012. Because of the importance of keeping accurate and sufficient treatment records, both for the patient and for the practitioner, the article is republished here with non-substantive changes.***

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A reader has asked me to write an article addressing the following: "***Please discuss the ins and outs of documentation of sessions. Protecting the client's confidentiality by not writing a lot of detail in progress notes that are submitted to an agency (if the therapist works as an affiliate/subcontractor), and potentially submitted to an insurance company or State funding agency, is important. But that seems to conflict with the therapist protecting oneself via thorough documentation. Colleagues' practices vary widely in this area and consensus is hard to find.***"

The reader asks that I discuss the "ins and outs" of documentation of sessions. I interpret this as wanting me to discuss the advantages and disadvantages of keeping detailed, thorough, or copious notes. The reader says that protecting confidentiality (e.g., if the therapist has a contract with an agency and submits progress notes to the agency) by not writing a lot of detail in progress notes is important, but observes that such practice may conflict with the need to protect oneself via thorough documentation. I do not think that these two objectives (self protection for the clinician and protecting the client's confidentiality) are necessarily mutually exclusive. I am not surprised that practices vary widely and that consensus is hard to find. Therapy, psychotherapy, or counseling, is both an art and a science. This reality is reflected in various ways when practitioners mold their clinical/business practices to reflect their own belief system about their work with the public.

From an ethical and legal point of view, a mental health practitioner should keep that amount of records that is consistent with sound clinical practice. Each practitioner desires to act as the reasonably prudent practitioner of like licensure would act under similar circumstances – or better. But, reasonably prudent practitioners (whoever they are) may differ with respect to how and why they keep patient treatment records. Of course, practitioners must be certain to abide by any applicable laws, regulations, or ethical standards that relate to the keeping of records – more particularly, to the content of records. In California, the law provides that it constitutes unprofessional conduct if the licensee fails to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered. This broadly worded law recognizes that the amount and kind of records kept

may vary with the circumstances, and it gives practitioners considerable flexibility.

Additionally, practitioners must be aware that there may be laws that require certain information to be contained in treatment records. For example, California practitioners are required by law to make entries into the records of minors who are treated without parental consent related to, among other things, the reason why the practitioner determined that contact with the child's parent was not appropriate. Another law in California requires that specific entries be made in the treatment records when access to records is denied to a patient on the grounds that access will result in detrimental or adverse consequences to the patient if he or she receives the records. Documentation in the records of informed consent when the practitioner will be providing services that are novel or experimental, or services involving a risk of harm to the patient, is another example of a time that requires particular entries. Practitioners in each state must learn what entries or information may be required to be in the records as a result of laws affecting various aspects of practice. The possible requirements of state regulations and professional association ethical standards cannot be overlooked.

With respect to issues of liability and negligence, it is a commonly accepted principle that mental health practitioners are not liable for honest mistakes in judgment. Liability generally attaches when the therapist has been negligent, e.g., a failure to act as the reasonably prudent practitioner of the same licensure would act under similar circumstances. Whenever exercising judgment on difficult or significant matters (e.g., a major change to the treatment plan), the practitioner should carefully document the patient's treatment record with the reasons why such judgment was used in the particular instance. Thus, if a practitioner was deciding whether or not to attempt to warn an intended victim of the patient's threatened violence, or was considering notifying a loved one about the patient's danger of self harm, the rationale for any action taken (or not taken) should be documented. When difficult clinical decisions are to be made, the practitioner will often consult with colleagues. This too should be documented. By doing so, the practitioner's judgment, even though it may not have had the desired result, may not amount to negligence.

Accurate and thorough record keeping can protect both the practitioner and the client. The client may be involved in litigation or other disputes which require proof that he or she suffered emotional harm before being entitled to any recovery of money damages. Patients who file for a variety of insurance benefits (group health, workers' compensation, disability insurance) may be required to prove mental health impairment and the need for medically necessary treatment. The practitioner may be sued by the patient for malpractice, may have another health practitioner request records for purposes of treatment, may have to undergo peer review or licensing board investigation, or may otherwise have to justify his or her actions and clinical judgment. Accurate and complete records will likely assist the practitioner and the patient in many circumstances, not the least of which relates to providing quality mental health care. Inadequate records can jeopardize the practitioner's and the patient's position in litigation and otherwise.

Therapists must often balance competing interests when determining record content. Sometimes a patient will request that minimal records be kept, or that certain information not be recorded. Like other

areas of practice, this requires that the practitioner exercise good judgment – that is, act prudently and in the best interests of the patient (without jeopardizing his/her license). In a sense, you are damned if you keep detailed records and damned if you don't. With respect to litigation, for example, the more you record, the more an opposing attorney will have at his or her disposal for criticism and cross-examination. The less you have in the way of records, the more you may be subject to criticism for inadequate documentation of your treatment. This is the reality of our adversarial judicial system. Your job is to treat patients and to keep adequate clinical notes to assist you and perhaps others who may later treat the patient.

Whether or not confidential patient information and records may or must later be disclosed depends upon the totality of circumstances involved and the legal issues of confidentiality and psychotherapist-patient privilege. Whether the records are sparse or thorough, they are protected by the ethical and legal duty of a therapist or counselor of confidentiality. Generally, records are not released without the signed authorization of the patient. Generally, the psychotherapist-patient privilege protects the records and the testimony of the practitioner from discovery in litigation. Therapists and counselors inform their clients, at the beginning of the relationship, about confidentiality (and sometimes, about the psychotherapist-patient privilege) and the exceptions to confidentiality (and sometimes, the exceptions to the privilege). Some exceptions are mandatory and others are permissive. The amount of time spent discussing this important aspect of treatment depends upon the practices and philosophies of individual practitioners, but its importance should not be under-estimated.

When treatment is provided as a subcontractor or an employee of an organization, as opposed to a private practitioner, it is important that the client understand whether and why the records may be seen by others within the entity that has the relationship with the client. The agency or organization responsible for the care should also inform the client about the limits of confidentiality outside of the entity. It is important for the patient to know what kind of information may be shared with an insurance company or governmental entity that is paying for a portion or all of the care. For those practitioners who are either "covered providers" under HIPAA or simply abide by its provisions, patients are given a Notice of Privacy Practices where disclosures are made and information provided concerning the confidentiality of the records. Patients should know (as the law provides in California and as per HIPAA regulations) that the provider may share information with other health care providers or health facilities without the patient's written authorization if the disclosures are for the purposes of diagnosis or treatment of the patient.

So – what kind of practice do you have? How do you hold yourself out to the public? Do you view your practice, because you do a lot of insurance billing, as a place where people are coming to you for the diagnosis and treatment of mental disorders? Do you see yourself as a health care provider? Do you deliver mental health services that can have a tremendous effect upon people's lives? Are you practicing psychotherapy? If the answer to one or more of these questions is "yes," then it seems to me that you would want to keep accurate and thorough records. The reader who asked me to write about this topic suggests that thorough documentation helps protect the therapist. I agree. Most therapists that I have talked with are interested in protecting themselves – as a first priority.

Not every detail or every word spoken need be documented. There is no magic formula for determining what information should be documented and what information need not be documented, since individual judgment will differ from practitioner to practitioner – depending upon a whole host of factors. Practitioners should keep in mind that they are providing health care services, that the purpose of the recordkeeping is to aid in the present and future treatment of the patient, and that they protect themselves (usually) by having accurate and thorough records. Privilege and confidentiality protect the records and the information in the records, and thus, the privacy interests of the patient. As mentioned above, the client should know or learn that confidentiality and privilege are not absolutes – that is, there are times when the client may not enjoy these protections. This may be so either because of the client's actions (e.g., filing a lawsuit alleging psychological harm or signing an authorization form) or because of public policy reasons (e.g., mandated child abuse reporting or warning an intended victim or notifying the police of a patient's imminent and serious threat of physical violence).