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TREATMENT OF MINORS

In Pennsylvania, the age of majority is 18 (23 P. S. §5101). Prior to age 18, minors have a limited ability to make binding legal decisions. The question arises, therefore, as to whose consent is required for the voluntary outpatient mental health examination or treatment of the less than 18-year-old minor. This issue generally depends on the legal custody and the age of the minor.

In 1970, the Pennsylvania legislature adopted the Minors' Consent to Medical Care Statute (35 P.S. §10101). This statute stated that other than in a number of limited situations, such as if the minor is married, a high school graduate, or emancipated, parental or guardian consent is necessary to provide medical treatment to the less than 18-year-old minor. The statute was silent, however, as to the consent necessary to provide mental health treatment to a minor.

In January 2005, the Minors' Consent to Medical Care Statute was amended to address the voluntary outpatient mental health examination or treatment of a minor (35 P. S. §10101.1). On July 23, 2020, Act 65 of 2020 further amended the statute.

Pursuant to the Minors' Consent to Medical Care Statute, "mental health treatment" is defined as follows:

> A course of treatment, including evaluation, diagnosis, therapy and rehabilitation, designed and administered to alleviate an individual's pain and distress and to maximize the probability of recovery from mental illness. This term also includes care and other services which supplement treatment and aid or promote recovery (35 P. S. §10101.1(a)(10)(b)).

This definition, in essence, encompasses what mental health professionals generally refer to as a mental health evaluation or ongoing psychotherapy.

The Minors' Consent to Medical Care Statute distinguishes between minors less than 14 years of age, and minors 14 to 17 years of age.

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For minors less than 14 years old, the consent of a parent is required prior to instituting the voluntary outpatient mental health examination or treatment of the minor (35 P.S. §10101.1(a)(1)).

This statute does not state that such examination or treatment *shall* be instituted in these situations. Rather, the statute states that such examination or treatment of the less than 14-year-old minor *may* be instituted with the consent of a parent. In addition, as noted below, this provision also must be read in conjunction with the *Grossman* decision.

Minors 14 to 17 years of age have two possible avenues of consent. First, if the minor has the capacity to make mental health treatment decisions, the 14 to 17-year-old minor may consent to their own examination or treatment, without any parental consent (35 P. S. §10101.1(a)(2)). Second, a parent can consent to the examination or treatment of the 14 to 17-year-old minor, absent the consent of the minor (35 P. S. §10101.1(a)(1)).

On July 23, 2020, several amendments were made to the Minors' Consent to Medical Care Statute. One of these 2020 amendments reads as follows:

> A minor or another parent or legal guardian may not abrogate consent provided by a parent or legal guardian on the minor's behalf to voluntary…outpatient treatment… (35 P. S. §10101.1(a)(3)).

For minors who are 14 to 17 years old, there has been a general consensus that a parent may not negate the right of a 14 to 17-year-old minor to seek treatment on their own, even if a court has issued an order of shared legal custody. In the past, this interpretation has been applied by Pennsylvania licensing board prosecuting attorneys in cases of shared legal custody.

The thrust of the 2020 amendment is unclear, however, as it pertains to parental consent, especially in cases of shared legal custody.

Under the prior version of the statute, the consent of only one parent was required where there was no court order of shared legal custody. It was assumed, therefore, that absent a court order of shared legal custody, the nonconsenting parent could not abrogate the consent of the consenting parent. Pursuant to the 2020 amendment of the statute, this assumption has been codified by more specific language.

It is unclear, however, whether this amendment also was intended to address the issue of parental consent in a shared legal custody situation.

More specifically, as it shall be described below, it is unclear whether this amendment was added merely to clarify the existing rule in non-shared legal custody situations, or whether this amendment was added to grant more substantive rights to parents in shared legal custody situations.

In addition, even in situations where the consent of only one parent is required, the Minors' Consent to Medical Care Statute does not state that the mental health examination or treatment of the minor child *shall* be instituted following the consent of a parent.

Rather, the statute states that the mental health examination or treatment of the minor child *may* be rendered following the consent of a parent.

For this reason, in addition to obtaining the requisite informed consent, the potential treatment provider, prior to instituting any clinical intervention, also must consider and balance the clinical issues associated with the case at hand.

More specifically, when providing mental health examination and treatment to minors of any age, it often is helpful to have the permission, involvement, and input of both parents, even with older adolescents. Such commitment and input by both parents may be necessary to effectuate a positive clinical outcome in the case at hand. In addition, it is necessary for the treatment provider to remain a neutral party and maintain professional boundaries, especially in cases that involve more contentious or high conflict families.

In this regard, the legal ability to institute the mental health examination or treatment of a minor child by the consent of a parent is different from the clinical question as to whether such examination or treatment, in fact, should be instituted. This clinical question must be answered on a case-by case-basis.

Shared Legal Custody

Custody involves the physical custody and the legal custody of the minor child. The physical custody and the legal custody of the minor child can be sole or shared in nature.

The written custody agreement or custody order generally contain provisions outlining the physical and the legal custody of the minor. It is highly recommended, therefore, that prior to instituting any type of mental health examination or treatment of a minor child, the potential treatment provider obtain a copy of the prevailing custody agreement or custody order to determine the legal custody status of the child.

Pennsylvania law defines legal custody as the right to make major decisions on behalf of the child, including, but not limited to, medical, religious, and educational decisions (23 P. S. §5322(a)). Section 23 P. S. §5322(a), however, does not define further what constitutes a major decision in a shared legal custody situation.

The question arises, therefore, as to whether under 23 P. S. §5322(a), the decision to seek the voluntary outpatient mental health examination or treatment of a minor child constitutes making a major decision on behalf of the child.

In February 2000, a Pennsylvania psychologist underwent a Pennsylvania State Board of Psychology licensing proceeding related to the issue of evaluating a minor child where the parents had shared legal custody of the minor child. The proceeding involved interpretations American Psychological Association Standards and Guidelines, Pennsylvania custody law, and Pennsylvania case law.

Following an adverse Board finding, the case was appealed to the Commonwealth Court of Pennsylvania, the Pennsylvania appellate court that reviews licensing board determinations. The Commonwealth Court appeal was decided on June 2, 2003 (*Jan C. Grossman v. State Board of Psychology*, 825 A.2d 748).

In *Grossman*, the psychologist was retained by a mother's attorney in a 1996 custody matter in which the mother and father shared legal custody of their minor child. The psychologist subsequently met with the minor child on two occasions.

At the time of the two meetings with the minor child, the psychologist had obtained consent from the mother to meet with the minor child. At the time of the two meetings with the minor child, the psychologist had not obtained consent from the father to meet with the minor child. The psychologist subsequently testified at a custody trial regarding his clinical findings.

In February 2000, a formal complaint was filed against the psychologist. Following a finding adverse to the psychologist, the case was appealed to the Commonwealth Court of Pennsylvania.

In its 2003 opinion, the Commonwealth Court found that the psychologist had conducted a psychological evaluation of a minor child where the parents had shared legal custody. The Court found further that the psychological evaluation was conducted without first obtaining the consent of the child's two legal custodians.

The Court ruled, in part, that the behavior of the psychologist violated the standards of the American Psychological Association. The Commonwealth Court also based its opinion upon Pennsylvania custody law, as well as prior Pennsylvania appellate court decisions involving shared legal custody.

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One of the bases of appeal in *Grossman* concerned the question as to whether a request that a minor child undergo a psychological evaluation, when the parents share legal custody, constituted a major decision, thereby requiring the consent of both legal custodians. The Commonwealth Court answered this question in the affirmative.

That is, the Commonwealth Court found that a decision to obtain a psychological evaluation of a minor child is a major decision that is encompassed within the statutory definition of legal custody.

For this reason, the Commonwealth Court held that the consent of all legal custodians is necessary prior to conducting a psychological evaluation of a minor child in a shared legal custody situation.

To date, no Pennsylvania Commonwealth Court or Pennsylvania Supreme Court case has overturned the *Grossman* decision.

Rather, this decision has been cited in subsequent cases in which psychologists have been found to have transgressed this rule (see, for example, *Laurie S. Pittman, Ph.D. v. Bureau of Professional and Occupational Affairs, State Board of Psychology*, unreported Commonwealth Court opinion, No. 1007 C.D. 2018, filed June 12, 2019). In addition, this decision has been utilized in cases involving Pennsylvania licensed social workers, marriage and family therapists, and professional counselors.

As outlined above, on January 24, 2005, two years following the 2003 *Grossman* Commonwealth Court decision, the Pennsylvania state legislature amended the Minors Consent to Medical Care Statute. For the first time, the Pennsylvania legislature addressed what type of parental consent is necessary for the voluntary outpatient mental health examination or treatment of a minor child. On July 23, 2020, several amendments were made to the Minors' Consent to Medical Care Statute.

This Minors' Consent to Medical Care Statute raises a confounding legal question concerning the consent of both parents in a shared legal custody situation.

That is, pursuant to the 2003 *Grossman* Commonwealth Court opinion, if a court has issued an order of shared legal custody, the consent of both parents is required prior to conducting the voluntary outpatient mental health examination or treatment of the minor child.

Pursuant to the Minors' Consent to Medical Care Statute, however, the consent of only "a" parent is required prior to conducting the voluntary outpatient mental health examination or treatment of a minor child.

And, to confuse things even further, under the Minors' Consent to Medical Care Statute, no parental consent is necessary to conduct the voluntary outpatient examination or treatment of the greater than 14-year-old minor who requests treatment and is capable of providing their own informed consent. In the past, this interpretation has been accepted in a shared legal custody situation.

It presently is unclear, however, whether the consent of both parents is required in a shared legal custody situation where the minor is under the age of 14, or where the minor over the age of 14 does not request the examination or treatment.

In such shared legal custody situations, which rule applies: The Court Order requiring the consent of both parents, or the Minors' Consent to Medical Care Statute which allows "a" parent to consent?

From 2003 through the current time, the prevailing interpretation has been that a Court Order providing for shared legal custody takes precedence over the Minors' Consent to Medical Care Statute. This interpretation has been relied upon by the state attorneys who prosecute licensing board complaints; the Pennsylvania State Board of Psychology; and the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors.

This issue of whether a Court Order containing a shared legal custody provision prevails over the Minors' Consent to Medical Care Statute was discussed during the executive session portion of the Pennsylvania State Board of Psychology's December 2, 2019 meeting. Such executive session discussions are held outside the presence of the public.

The Psychology Board continued their discussion during the public portion of their meeting. This public discussion is contained in the Final Minutes of the Psychology Board's December 2, 2019, meeting (p. 26-28), and can be found on the Pennsylvania State Board of Psychology website.

In the Final Minutes of the Psychology Board's December 2, 2019 meeting, the Psychology Board discussed whether the original 2005 amendments to the Minors' Consent to Medical Care Statute abrogated the *Grossman* opinion as it applies to the voluntary outpatient mental health examination and treatment of a minor child in a shared legal custody situation. It should be noted that these comments were made prior to the 2020 amendments to the Minors' Consent to Medical Care Statute.

In the Final Minutes of its December 2, 2019 meeting, the Psychology Board noted that the American Psychological Association Ethics Code does not require the consent of both parents for a child to receive treatment. The discussion noted that for this reason, the

reliance upon the American Psychological Association ethics code in terms of informed consent was misplaced. The Board also noted that the American Psychological Association Specialty Guidelines on Child Custody evaluations do not require the consent of both parents, although the Board stated that it would be below the standard of care to perform a child custody evaluation without obtaining the consent of both parents.

In discussing this issue, the Psychology Board did not reference the Pennsylvania legal custody statute or the Pennsylvania appellate caselaw that was cited in the 2003 Commonwealth Court *Grossman* opinion.

In addition, it should be noted that this issue has not yet been addressed by the Pennsylvania State Board of Social Workers, Marriage and Family Therapists, and Professional Counselors.

Current State of the Law

In general, the rules governing the practice of Pennsylvania mental health professionals is governed by Pennsylvania statutes, Pennsylvania caselaw, Pennsylvania board regulations, and Pennsylvania board decisions.

There also is the legal doctrine of *stare decisis,* the doctrine by which judges are expected to respect precedent that has been established by prior court decisions.

As outlined above, to date, no Pennsylvania appellate court has overturned *Grossman.*

The 2020 amendments to the Minors' Consent to Medical Care Statute state in more specific language that consent of one parent for the voluntary outpatient mental health examination or treatment of a minor child may not be abrogated by the other parent.

Since this rule was implicit in the prior version of the statute, it is unclear whether the Pennsylvania state legislature intended to clarify the existing rule in situations where there is no shared legal custody, or whether it was the intent of the Pennsylvania state legislature to overrule the *Grossman* decision in situations where there is shared legal custody.

In this regard, how should a Pennsylvania mental health professional proceed?

For example, one parent with shared legal custody of a child under the age of 14 requests that the minor child undergo a mental health evaluation or treatment. Can or should the mental health professional proceed with the evaluation or treatment?

In such a situation, there is a question as to what, if any, legal jeopardy the mental health professional may be placed if the mental health professional agrees to examine or treat the minor child.

That is, will the Pennsylvania prosecuting attorneys who review and file licensing board complaints continue to file complaints based upon the 2003 *Grossman* decision?

If a formal board complaint or a malpractice action is filed against the mental health professional, will the mental health professional be able to present a successful defense to a *Grossman* violation based upon the Minors' Consent to Medical Care Statute?

Presently, there are no definitive answers to these questions.

Pending further legal clarification, therefore, it may be prudent, in shared legal custody situations, for mental health professionals to adhere to the joint consent requirements contained in the *Grossman* decision prior to instituting the voluntary outpatient mental health examination or treatment of a minor child.

September 6, 2021

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§ 41.57. Professional records.

(a) This section sets out the Board's minimum requirements for the maintenance of professional records by psychologists. These requirements express the Board's belief that a psychologist's commitment to the welfare of a client/patient includes the duty to record accurately that person's progress through the evaluation and intervention process. Compliance with this section does not excuse psychologists from complying with stricter standards otherwise imposed by State or Federal law or regulation or by institutional requirements.

(b) A psychologist shall maintain a legible record for each client/patient which includes, at a minimum:

(1) The name and address of the client/patient and, if the client/patient is a minor, the names of the parents or the name of the legal guardian. If a minor's parents are separated, notation of legal custodial arrangements is required.

(2) The presenting problem or purpose or diagnosis.

(3) The fee arrangement.

(4) The date and substance of each service contact.

(5) Test results or other evaluative results obtained and basic test data from which they were derived.

(6) Notation and results of formal consults with other providers.

(7) A copy of all test or other evaluative reports prepared as part of the professional relationship.

(8) Authorizations, if any, by the client/patient for release of records or information.

(c) A psychologist shall store and dispose of written, electronic and other records in a manner which insures their confidentiality.

(d) To meet the requirements of this section, so as to provide a formal record for review, but not necessarily for other legal purposes, a psychologist shall assure that all data entries in professional records are maintained for at least 5 years after the last date that service was rendered. A psychologist shall also abide by other legal requirements for record retention, even if longer periods of retention are required for other purposes.

(e) A psychologist shall provide for the confidential disposition of records in the event of the psychologist's withdrawal from practice, incapacity or death.

(f) Failure to comply with this section shall subject the violator to disciplinary action under section 8(a)(15) of the act (63 P. S. § 1208(a)(15)).

Authority

The provisions of this § 41.57 issued under section 3.2(2) of the Professional Psychologists Practice Act (63 P. S. § 1203.2(2)).

Source 88

The provisions of this § 41.57 adopted June 12, 1992, effective June 13, 1992, 22 Pa.B. 2980.

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Record Keeping Guidelines

American Psychological Association

Introduction

These guidelines are designed to educate psychologists and provide a framework for making decisions regarding professional record keeping. State and federal laws, as well as the American Psychological Association's (APA, 2002b) "Ethical Principles of Psychologists and Code of Conduct" (hereafter referred to as the Ethics Code), generally require maintenance of appropriate records of psychological services. The nature and extent of the record will vary depending upon the purpose, setting, and context of the psychological services. Psychologists should be familiar with legal and ethical requirements for record keeping in their specific professional contexts and jurisdictions. These guidelines are not intended to describe these requirements fully or to provide legal advice.

Records benefit both the client[1] and the psychologist through documentation of treatment plans, services provided, and client progress. Record keeping documents the psychologist's planning and implementation of an appropriate course of services, allowing the psychologist to monitor his or her work. Records may be especially important when there are significant periods of time between contacts or when the client seeks services from another professional. Appropriate records can also help protect both the client and the psychologist in the event of legal or ethical proceedings. Adequate records are generally a requirement for third-party reimbursement for psychological services.

The process of keeping records involves consideration of legal requirements, ethical standards, and other external constraints, as well as the demands of the particular professional context. In some situations, one set of considerations may suggest a different course of action than another, and it is up to the psychologist to balance them appropriately. These guidelines are intended to assist psychologists in making such decisions.

Guidelines and Use of Language

Psychological practice entails applications in a wide range of settings for a variety of potential clients. This document was written to provide broad guidance to providers of services (e.g., assessment, diagnosis, prevention, treatment, psychotherapy, consultation). Extension of the guidelines to some areas of practice (e.g., industrial/organizational, consulting psychology) may likely call for modifications, although some of the same general principles may be useful.

The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help facilitate a high level of practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

These guidelines are intended to provide psychologists with a general framework for considering appropriate courses of action or practice in relation to record keeping. Record keeping procedures are directed, to some extent, by the Ethics Code and legal and regulatory requirements. Within these guidelines, more directive language has been used when a particular guideline is based specifically on mandatory provisions of the Ethics Code or law. However, some areas are not addressed in those enforceable standards and regulations. In these areas, more aspirational language has been used. This document aims to elaborate and provide assistance to psychologists as they attempt to establish their own record keeping policies and procedures.

This revision of the 1993 "Record Keeping Guidelines" was completed by the Board of Professional Affairs (BPA) Committee on Professional Practice and Standards (COPPS). Members of COPPS during the development of this document were Eric Y. Drogin (Chair, 2007), Mary A. Connell (Chair, 2006), William E. Foote (Chair, 2005), Cynthia A. Sturm (Chair, 2004), Kristin A. Hancock (Chair, 2003), Armand R. Cerbone, Victor de la Cancela, Michele Galietta, Larry C. James (BPA liaison, 2004–2006), Leigh W. Jerome (BPA liaison, 2003), Sara J. Knight, Stephen Lally, Gary D. Lovejoy, Bonnie J. Spring, Carolyn M. West, and Philip H. Witt. COPPS is grateful for the support and guidance of the BPA, particularly to BPA Chairs Kristin A. Hancock (2006), Rosie Phillips Bingham (2005), and Jalie A. Tucker (2004). COPPS also acknowledges the consultation of Lisa R. Grossman, Stephen Behnke, Lindsay Childress-Beatty, Billie Hinnefeld, and Alan Nessman. COPPS extends its appreciation to the APA staff members who facilitated the work of COPPS: Lynn F. Bufka, Mary G. Hardiman, Laura Kay-Roth, Ernestine Penniman, Geoffrey M. Reed, and Omar Rehman.

Correspondence concerning this article should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

[1] The term *client* is used throughout this document to refer to the child, adolescent, adult, older adult, family, group, organization, community, or other population receiving psychological services. Although it is recognized that the client and the recipient of services may not necessarily be the same entity (APA Ethics Code, Standard 3.07), for economy the term *client* is used in place of *service recipient.*

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It should also be noted that APA policy generally requires substantial review of the relevant empirical literature as a basis for establishing the need for guidelines and for providing justification for the guidelines' statements themselves (APA, 2005). There is relatively little empirical literature, however, that bears specifically on record keeping. Therefore, these guidelines are based primarily on previous APA policy, professional consensus as determined by the APA Board of Professional Affairs (BPA) Committee on Professional Practice and Standards (COPPS), the review and comment process used in developing this document, and, where possible, existing ethical and legal requirements.

Interaction With State and Federal Laws

Specific state and federal laws and regulations govern psychological record keeping. To the extent possible, this document attempts to provide guidelines that are generally consistent with these laws and regulations. In the event of a conflict between these guidelines and any state or federal law or regulation, the law or regulation in question supersedes these guidelines. It is anticipated that psychologists will use their education, skills, and training to identify the relevant issues and attempt to resolve conflicts in a way that conforms to both law and ethical practice.

HIPAA

Psychologists who are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) should be aware of certain record keeping requirements and considerations under HIPAA's Security Rule and Privacy Rule (see *HIPAA Administrative Simplification, Regulation Text, 45 CFR Parts 160, 162 and 164*; U.S. Department of Health and Human Services, Office for Civil Rights, 2006). These guidelines indicate some key areas in which HIPAA requirements or considerations impact record keeping. However, detailed coverage of the requirements for HIPAA compliance is beyond the scope of this document, and the rules related to HIPAA and their interpretation may change over the lifetime of these guidelines. Accordingly, consultation with other sources of information regarding the implications of HIPAA for psychologists is recommended.[2]

Expiration

These guidelines are scheduled to expire 10 years from February 16, 2007 (the date of adoption by the APA Council of Representatives). After this date, users are encouraged to contact the APA Practice Directorate to determine whether this document remains in effect.

Background

In 1988, APA's Board of Professional Affairs (BPA) requested that its Committee on Professional Practice and Standards (COPPS) examine the possible usefulness of guidelines on record keeping for psychologists. Interviews with psychologists indicated that such guidance would indeed be useful. COPPS also surveyed state laws and regulations related to record keeping by psychologists and found them to be vague and to vary substantially across jurisdictions. Based on these findings, BPA directed COPPS to undertake the development of "Record Keeping Guidelines" (APA, Committee on Professional Practice and Standards, 1993), which were subsequently adopted as APA policy.

As part of a process of reviewing guidelines over time to ensure their continued relevance and applicability, BPA noted that the guidelines did not account for new questions raised by rapidly changing technology, particularly electronic communications and electronic media. Further, it was clear that HIPAA had important implications for record keeping by psychologists. In particular, HIPAA's Privacy Rule and Security Rule have implications for the development, maintenance, retention, and security of medical and mental health records. In light of these developments, BPA directed COPPS to revise the "Record Keeping Guidelines."

COPPS began with an assessment of APA member experience with the current guidelines. The 1993 "Record Keeping Guidelines" were posted on the APA Web site for member and public comment in the light of a possible revision. A call for comments was published in the *APA Monitor* and circulated to state, provincial, and territorial psychological associations and to APA divisions. COPPS also surveyed current professional literature on record keeping. Relevant provisions of the Ethics Code (APA, 2002b), which had been extensively revised since the development of the 1993 "Record Keeping Guidelines," were examined in detail, as were the ethics codes and relevant policies of several other mental health professions. COPPS also considered the implications of current federal and state laws and regulations, including HIPAA. COPPS reviewed the questions received from members by the APA Practice Directorate Legal and Regulatory Affairs Office and the APA Ethics Office about record keeping practices. Most commonly, these questions concerned the content of records, management and maintenance of records, electronic records, retention of records, and compliance with rapidly changing state and federal requirements for record keeping. Finally, other APA practice guidelines were examined to ensure internal consistency of APA policies.

After drafting a proposed revision, COPPS sought feedback and incorporated suggestions from the APA Ethics and Legal offices. BPA reviewed and approved the draft for release for a Call for Comments. In the Call for Comments, input was sought from all APA divisions and individual members. COPPS presented the draft at APA Con-

[2] Resources regarding HIPAA, and HIPAA compliance for psychologists, are available at the U.S. Department of Health and Human Services, Office for Civil Rights Web site (www.hhs.gov/ocr/hipaa/) and in documents prepared by the APA Practice Organization (2003, 2005), solely or in collaboration with the APA Insurance Trust (APA Practice Organization & APA Insurance Trust, 2002).

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ventions on July 30, 2004 and August 11, 2006, seeking input from APA members. Comments and recommendations were incorporated by COPPS, and a revised draft was submitted to BPA on November 9, 2006. BPA approved the draft in principle and placed it on the agenda for Board of Directors approval in principle during its December 8–9, 2006 meeting. The Board of Directors approved the draft in principle on December 9, 2006, and COPPS further revised the draft, incorporating BPA's recommended changes, during its December 8–9, 2006 meeting and throughout the end of 2006. The final draft was forwarded to Council for its approval at its February 2007 meeting and was approved on February 16, 2007.

Guidelines

Guideline 1—Responsibility for Records: Psychologists generally have responsibility for the maintenance and retention of their records.

Rationale

Psychologists have a professional and ethical responsibility to develop and maintain records (Ethics Code, Standard 6.01). The psychologist's records document and reflect his or her professional work. In some circumstances, the records are the only way that the psychologist or others may know what the psychologist did and the psychologist's rationale for those actions. As a consequence, the psychologist aspires to create records that are consistent with high-quality professional work. If the psychologist is later questioned about services or billing, the availability of accurate records facilitates explanation and accountability.

Application

A psychologist makes efforts to see that legible and accurate entries are made in client records as soon as is practicable after a service is rendered. Psychologists are urged to organize their records in a manner that facilitates their use by the psychologist and other authorized persons. Psychologists ensure that supervisees, office staff, and billing personnel who handle records are appropriately trained regarding awareness of and compliance with ethical and legal standards related to managing confidential client information (Ethics Code, Standards 2.05 and 6.02). Where appropriate, a psychologist maintains control over clients' records, in accordance with the policies of the institution in which psychological services are provided and consistent with Ethics Code, Standard 6.01. To the degree that there are conflicts between the institutional policies and procedures and the Ethics Code, psychologists appropriately address these issues as outlined in the Ethics Code (Standard 1.03), clarifying the nature of the conflict, making known their commitment to the Ethics Code, and, to the extent feasible, resolving the conflict in a way that permits adherence to the Ethics Code.

Guideline 2—Content of Records: A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist's jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees.

Rationale

The Ethics Code (Standard 6.01) sets forth reasons why psychologists create and maintain records. Based on various provisions in the Ethics Code, in decision making about content of records, a psychologist may determine what is necessary in order to (a) provide good care; (b) assist collaborating professionals in delivery of care; (c) ensure continuity of professional services in case of the psychologist's injury, disability, or death or with a change of provider; (d) provide for supervision or training if relevant; (e) provide documentation required for reimbursement or required administratively under contracts or laws; (f) effectively document any decision making, especially in high-risk situations; and (g) allow the psychologist to effectively answer a legal or regulatory complaint.

Application

In making decisions about the content of records, the psychologist takes into account factors such as the nature of the psychological services, the source of the information recorded, the intended use of the records, and his or her professional obligations. Some hospitals, clinics, prisons, or research organizations mandate record format, specific data to be gathered and recorded, and time frames within which the records are to be created. A psychologist endeavors to include only information germane to the purposes for the service provided (Ethics Code, Standard 4.04). Additionally, consistent with the Ethics Code (Principle A), psychologists are sensitive to the potential impact of the language used in the record (e.g., derogatory terms, pathologizing language) on the client.

Considerations Regarding the Level of Detail of the Record

A psychologist makes choices about the level of detail in which the case is documented. Psychologists balance client care with legal and ethical requirements and risks. Information written in vague or broad terms may not be sufficient if more documentation is needed (e.g., for continuity of care, mounting an adequate defense against criminal, malpractice, or state licensing board complaints). However, some clients may express a desire for the psychologist to keep a minimal record in order to provide maximum protection and privacy. Although there may be advantages to keeping minimal records, for example, in light of risk management concerns or concerns about unintended disclosure, there are, alternately, legitimate arguments for keeping a highly detailed record. Those may include such

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factors as improved opportunities for the treatment provider to identify trends or patterns in the therapeutic interaction, enhanced capacity to reconstruct the details of treatment for litigation purposes, and more effective opportunities to use supervision and consultation. The following issues may provide a guide to assist the psychologist in wrestling with these tensions:

The client's wishes. For a variety of reasons, clients may express a wish that limited records of treatment be maintained. In some situations, the client may require limited record keeping as a condition of treatment. The psychologist then considers whether treatment can be provided under this condition.

Emergency or disaster relief settings. When psychologists provide crisis intervention services to people on an emergency relief basis, the records that are created may be less substantial because of the situational demands. The psychologist may be guided by the oversight agency regarding necessary elements for the record. For example, disaster relief agencies may require only cursory identifying information, the date of service, a brief summary of the service provided, and the provider's name. There may be limited opportunity to keep as detailed records as would be kept in a less urgent situation, particularly in the short-term or immediate crisis. In some situations, such as disaster relief following an airplane crash or a hurricane, no further intervention beyond the on-site contact may occur and, given the brevity and sheer number of services provided, highly detailed records may be impossible to construct even after the crisis.

Alteration or destruction of records. Many statutes, regulations, and rules of evidence prohibit the alteration or removal of information once a record has been made. In the context of litigation, addition or removal of information from a record that has been subpoenaed or requested by court order may create liability for the psychologist. Psychologists may wish to seek consultation regarding relevant state and federal law before changing an existing record. It is recommended that later additions made to a record be documented as such.

Legal/regulatory. Some statutes and regulations mandate inclusion or prohibit exclusion of particular information. For example, an institutional rule for record keeping may prohibit reference to sealed juvenile records or to HIV test results, or a statute may govern disclosure of information about treatment for chemical dependency. The psychologist takes into account the statutes and regulations that govern practice and heeds mandates in making decisions about record detail.

Agency/setting. Psychologists providing psychological services within an institution consider institutional policies and procedures in making decisions about the level of detail in the record (See Guideline 10).

Third-party contracts. The psychologist considers whether the decision to maintain less detailed records deviates from contracts between the psychologist and third-party payers. Many third-party payers' contracts require specific information to be included within the record. Psychologists who sign but do not abide by contracts with such payers will potentially experience a number of adverse consequences (e.g., required reimbursement of previously received funds, legal actions).

The record of psychological services may include information of three kinds.

Information in the client's file:

- identifying data (e.g., name, client ID number);
- contact information (e.g., phone number, address, next of kin);
- fees and billing information;
- where appropriate, guardianship or conservatorship status;
- documentation of informed consent or assent for treatment (Ethics Code, Standard 3.10);
- documentation of waivers of confidentiality and authorization or consent for release of information (Ethics Code, Standard 4.05);
- documentation of any mandated disclosure of confidential information (e.g., report of child abuse, release secondary to a court order);
- presenting complaint, diagnosis, or basis for request for services;
- plan for services, updated as appropriate (e.g., treatment plan, supervision plan, intervention schedule, community interventions, consultation contracts);
- health and developmental history.

For each substantive contact with a client:

- date of service and duration of session;
- types of services (e.g., consultation, assessment, treatment, training);
- nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts);
- formal or informal assessment of client status.

The record may also include other specific information, depending upon the circumstances:

- client responses or reactions to professional interventions;
- current risk factors in relation to dangerousness to self or others;
- other treatment modalities employed, such as medication or biofeedback treatment;
- emergency interventions (e.g., specially scheduled sessions, hospitalizations);
- plans for future interventions;
- information describing the qualitative aspects of the professional–client interaction;
- prognosis;
- assessment or summary data (e.g., psychological testing, structured interviews, behavioral ratings, client behavior logs);
- consultations with or referrals to other professionals;
- case-related telephone, mail, and e-mail contacts;
- relevant cultural and sociopolitical factors.

Guideline 3—Confidentiality of Records: The psychologist takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.

Rationale

Confidentiality of records is mandated by law, regulation, and ethical standards (Ethics Code, Standards 4.01 and 6.02). The assurance of confidentiality is critical for the provision of many psychological services. Maintenance of confidentiality preserves the privacy of clients and promotes trust in the profession of psychology.

Application

The psychologist maintains records in such a way as to preserve their confidentiality. The psychologist develops procedures to protect the physical and electronic record from inadvertent or unauthorized disclosure (see Guideline 5). Psychologists are familiar with the ethical standards regarding confidentiality, as well as state and federal regulations and statutes (e.g., HIPAA, licensing laws, mandated reporting of abuse). Psychologists strive to be aware of the legal and regulatory requirements governing the release of information (e.g., some jurisdictions prohibit the re-release of mental health records, records of sexually transmitted diseases, or chemical dependency treatment records). When the psychologist employs clerical or testing personnel, he or she is required by the Ethics Code (Standard 2.05) to take reasonable steps to ensure that the employee's work is done competently. Therefore, the psychologist strives to educate employees about confidentiality requirements and to implement processes that support the protection of records and the disclosure of confidential information only with proper consent or under other required circumstances (e.g., mandated reporting, court order).

Psychologists may encounter situations in which it is not immediately apparent who should have access to records. For example, children in treatment following marital dissolution may be brought for services by one parent who wishes the record to be kept confidential from the other parent, or an adolescent who is near but has not quite reached the age of majority may request that records be kept confidential from the parent/guardian. A minor may have the legal prerogative to consent to treatment (e.g., for reproductive matters), but the parent may nevertheless press for access to the record. The psychologist is guided by the Ethics Code (providing that psychologists may disclose information to a legally authorized person on behalf of the client/patient unless prohibited by law; Ethics Code, Standard 4.05) as well as by state and federal regulations in these matters. Following marital dissolution, a psychologist may be unclear whether to release records to one of the parents, particularly when the release is not wanted by the other parent. In such a situation, the psychologist recognizes that the relevant court overseeing the marital dissolution may have already specified who has access to the child's treatment records.

Guideline 4—Disclosure of Record Keeping Procedures: When appropriate, psychologists inform clients of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of the records; Ethics Code, Standard 4.02).

Rationale

Informed consent is part of the ethical and legal basis of professional psychology procedures (Ethics Code, Standards 3.10, 8.02, 9.03, and 10.01), and disclosure of record keeping procedures may be a part of this process.

Application

Consistent with the APA's Ethics Code, psychologists obtain and document informed consent appropriate to the circumstances at the beginning of the professional relationship. In some circumstances, when it is anticipated that the client might want or need to know how records will be maintained, this process may include the disclosure of record keeping procedures. This may be especially relevant when record keeping procedures are likely to have an impact upon confidentiality or when the client's expressed expectations regarding record keeping differ from the required procedures.

The manner in which records are maintained may potentially affect the client in ways that may be unanticipated by the client. Psychologists are encouraged to inform the client about these situations. For example, in some medical settings, client records may become part of an electronic file that is accessible by a broad range of institutional staff (see Guideline 10). In some educational settings, institutional, state, and federal regulations dictate record keeping procedures that may expand the range of individuals who have access to the records of a school psychologist.

When a psychologist releases client records, with proper authorization to release information, they may be further distributed without the psychologist's or the client's consent. The psychologist may wish to alert the client of this potential at the outset of services or before consent for release is given. For example, after release in a litigation context, records may be placed in the public domain and be accessible to any member of the public. Another example of unwanted re-release may occur when records are sent, at the client's request, to another treating professional, whose handling of those records is then beyond the control of the psychologist who sent them.

Guideline 5—Maintenance of Records: The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.

Rationale

The usefulness of psychological service records often depends on the records being systematically updated and

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logically organized. Organization of client records in a manner that allows for thoroughness and accuracy of records, as well as efficient retrieval, both benefits the client and permits the psychologist to monitor ongoing care and interventions. In the case of the death or disability of the psychologist or of an unexpected transfer of the client's care to another professional, current, accurate, and organized records allow for continuity of care (see Guideline 13).

Application

The psychologist is encouraged to update active records to reflect professional services delivered to the client and changes in the client's status. The psychologist may use various methods to organize records to assist in storage and retrieval. Methods reflecting consistency and logic are likely to be most useful. For example, a logical file labeling system facilitates the search and recovery of records. The psychologist may consider dividing client files into two or more sections. Psychotherapy notes, as defined by HIPAA, are necessarily kept apart from other parts of the record. Additionally, client information that may be considered useful to others and that is intended to be shared with them may constitute a section. A psychologist may also consider, for purposes of convenience and organization, an additional section to include material generated by the client or by third parties, such as the client's family members, or from prior treatment providers. This might include, among other things, behavioral ratings or logs, diaries, journals, letters from the client's children, pictures or videos, or greeting cards. Psychological test data, because it may bear more careful consideration before being released, may be clustered and designated, within the file, to ensure that its release is appropriately considered.

A specific area of concern is the re-release of data that have been included in the client's record. When the psychologist is releasing the client's record, upon request and with consent, the psychologist is faced with the question of whether the client's previous therapist's records, for example, constitute a part of the record and should be released. The psychologist considers HIPAA regulations regarding psychotherapy notes,[3] the breadth of the records requested, and the client's wishes, along with the situational demands. For instance, when a psychologist is responding to a subpoena[4] for "any and all records" upon which the psychologist relied in forming opinions, it is generally necessary to re-release any third-party information included in the record. The psychologist may nevertheless provide advance notification to the client and allow sufficient time for objection to be raised before responding to such requests for records.

Guideline 6—Security: The psychologist takes appropriate steps to protect records from unauthorized access, damage, and destruction.

Rationale

Psychologists proceed with respect for the rights of individuals to privacy and confidentiality (Ethics Code, Principle E). Appropriate security procedures protect against the loss of or unauthorized access to the record, which could have serious consequences for both the client and psychologist.[5] Access to the records is limited in order to safeguard against physical and electronic breaches of the confidentiality of the information. Advances in technology, especially in electronic record keeping, may create new challenges for psychologists in their efforts to maintain the security of their records (see Guideline 9).

Application

The psychologist strives to protect the security of the paper and electronic records he or she keeps and is encouraged to develop a plan to ensure that these materials are secure.[6] In the security plan, two elements to be considered are the medium on which the records are stored and access to the records.

Maintenance. Psychologists are encouraged to keep paper records in a secure manner in safe locations where they may be protected from damage and destruction (e.g., fire, water, mold, insects). Condensed records may be copied and kept in separate locations so as to preserve a copy from natural or other disasters. Similarly, electronic records stored on magnetic and other electronic media may require protection from damage (e.g., electric fields or mechanical insult; power surges or outage; and attack from viruses, worms, or other destructive programs). Psychologists may plan for archiving of electronic data including file and system backups and off-site storage of data (See Guideline 9).

Access. Control of access to paper records may be accomplished by storing files in locked cabinets or other containers housed in locked offices or storage rooms. Psychologists protect electronic records from unauthorized access through security procedures (e.g., passwords, firewalls, data encryption and authentication). Consistent with legal and regulatory requirements and ethical standards (e.g., Ethics Code, Standard 6.02; HIPAA Privacy Rule and Security Rule), psychologists employ procedures to limit access of records to appropriately trained professionals and others with legitimate need to see the records.

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[3] See the HIPAA Privacy Rule (Standards for Privacy of Individually Identifiable Health Information, 2002).

[4] See "Strategies for Private Practitioners Coping With Subpoenas or Compelled Testimony for Client Records or Test Data" (APA, Committee on Legal Issues, 2006, or http://content.apa.org/journals/pro/37/2/215.pdf).

[5] For psychologists who are subject to HIPAA and keep electronic records, the HIPAA Security Rule requires a detailed analysis of the risk of loss of, or unauthorized access to, electronic records and detailed policies and procedures to address those risks (for more details regarding the Security Rule, see Health Insurance Reform: Security Standards, 2003) .

[6] If the psychologist is subject to HIPAA and maintains electronic records, the HIPAA Security Rule will generally require the development of security policies and procedures for those records (for more details regarding the Security Rule, see Health Insurance Reform: Security Standards, 2003).

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Guideline 7—Retention of Records: The psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements.

Rationale

A variety of circumstances (e.g., requests from clients or treatment providers, legal proceedings) may require release of client records after the psychologist's termination of contact with the client. Additionally, it is beneficial for the psychologist to retain information concerning the specific nature, quality, and rationale for services provided. The retention of records may serve not only the interests of the client and the psychologist but also society's interests in a fair and effective legal dispute resolution and administration of justice, when those records are sought to illuminate some legal issue such as the nature of the treatment provided or the psychological condition of the client at the time of services.

Application

In the absence of a superseding requirement, psychologists may consider retaining full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later. In some circumstances, the psychologist may wish to keep records for a longer period, weighing the risks associated with obsolete or outdated information, or privacy loss, versus the potential benefits associated with preserving the records (See Guideline 8).

There are inherent tensions associated with decisions to retain or dispose of records. Associated with these decisions are both costs and benefits for the recipient of psychological services and for the psychologist. A variety of circumstances can trigger requests for records even beyond 7 years after the psychologist's last contact with the client. For example, an earlier record of symptoms of a mental disorder might be useful in later diagnosis and treatment. In contrast, the client may be served by the disposal of the record as soon as allowed. For example, the client may have engaged in behavior as a minor that, if later disclosed, might prove demeaning or embarrassing. Also, retaining records over long intervals can be logistically challenging and expensive for the psychologist. The psychologist is encouraged to carefully weigh these matters in making decisions to retain or dispose of records.[7]

Guideline 8—Preserving the Context of Records: The psychologist strives to be attentive to the situational context in which records are created and how that context may influence the content of those records.

Rationale

Records may have a significant impact on the lives of clients (and prior clients). At times, information in a client's record is specific to a given temporal or situational context (e.g., the time frame and situation in which the services were delivered and the record was created). When that context changes over time, the relevance and meaning of the information may also change. Preserving the context of the record protects the client from the misuse or misinterpretation of those data in a way that could prejudice or harm the client.

Application

When documenting treatment or evaluation, the psychologist is attentive to situational factors that may affect the client's psychological status. The psychologist is often asked to assess or treat individuals who are in crisis or under great external stress. Those stresses may affect the client's functioning in that setting, so that the client's behavior in that situation may not represent the client's enduring psychological characteristics. For example, a child subjected to severe physical abuse may produce low scores in a cognitive assessment that may not accurately predict the child's future functioning. Or a psychologist writing a case summary regarding a client who had only been violent in the midst of a psychotic episode is careful to record the context in which the behavior occurred. The psychologist strives to create and maintain records in such a way as to preserve relevant information about the context in which the records were created.

Guideline 9—Electronic Records: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.

Rationale

The use of electronic methods and media compels psychologists to become aware of the unique aspects of electronic record keeping in their particular practice settings. These aspects include limitations to the confidentiality of these records, methods to keep these records secure, measures necessary to maintain the integrity of the records, and the unique challenges of disposing of these records. In many cases, psychologists who maintain electronic records will be subject to the HIPAA Security Rule, which requires a detailed analysis of the risks associated with electronic records. Conducting that risk analysis may be advisable even for psychologists who are not technically subject to HIPAA. The HIPAA Privacy Rules and Security Standards provide assistance to the practitioner in scrutinizing office practices such as assuring that personal health information is handled in a way designed to protect the privacy of

[7] The HIPAA Security Rule, if applicable, sets forth specific requirements and considerations for the disposal of electronic patient information and computers and devices that contain such information (for more details regarding the Security Rule, see Health Insurance Reform: Security Standards, 2003).

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clients; defining proper deidentification of case information for research or other purposes when deidentification is in order; and clearly defining the elements required in an authorization to release information. The discussion in this section addresses considerations beyond the requirements of the Security Rule.

Whether or not the Security Rule applies, rapid changes in the technology of service delivery, billing, and media storage have prompted psychologists to consider how to apply existing standards of psychological record keeping using these methods and media. Psychologists struggle with questions such as whether to communicate with clients through e-mail and how to allow for the secure transmission, storage, and destruction of electronic records. The ease of creating, transmitting, and sharing electronic records may expose psychologists to risks of unintended disclosure of confidential information.

Application

Psychologists may develop security procedures that fit the specific circumstances in which they work. Psychologists using online test administration and scoring systems may consider using a case identification number rather than the client's Social Security number as the record identifier. Psychologists using computers or other digital or electronic storage devices to maintain client treatment records may consider using passwords or encryption to protect confidential material.[8] The psychologist strives to become aware of special issues associated with using electronic methods and media and seeks training and consultation when necessary.[9]

Guideline 10—Record Keeping in Organizational Settings: Psychologists working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow the record keeping policies and procedures of the organization as well as the APA Ethics Code.

Rationale

Organizational settings may present unique challenges in record keeping. Organizational record keeping requirements may differ substantially from procedures in other settings. Psychologists working in organizational settings may encounter conflicts between the practices of their organization and established professional guidelines, ethical standards, or legal and regulatory requirements. Additionally, record ownership and responsibility is not always clearly defined. Often, multiple service providers access and contribute to the record. This potentially affects the degree to which the psychologist may exercise control of the record and its confidentiality.

Application

Three record keeping issues arise when psychologists provide services in organizational settings: conflicts between organizational and other requirements, ownership of the records, and access to the records.

The psychologist may consult with colleagues in the organization to support record keeping that serves the needs of different disciplines and while meeting acceptable record keeping requirements and guidelines. In addition, the psychologist may review local, state, and federal laws and regulations that pertain to that organization and its record keeping practices. In the event that there are conflicts between an organization's policies and procedures and the Ethics Code, psychologists clarify the nature of the conflict, make their ethical commitments known, and to the extent feasible, resolve the conflict consistent with those commitments (Ethics Code, Standard 1.03).

Record keeping practices may depend upon the nature of the psychologist's legal relationship with the organization. In some settings, the physical record of psychological services is owned by the organization and does not travel with the psychologist upon departure. However, in consultative relationships, record ownership and responsibility may be maintained by the psychologist. It is therefore helpful for psychologists to clarify these issues at the beginning of the relationship in order to minimize the likelihood of misunderstandings.

Often, rules for record creation and maintenance reflect requirements of all relevant disciplines, not only those related to psychological services. Treatment team involvement in service delivery may occasion wider access to records than usually exists in independent practice settings. Because others (e.g., physicians, nurses, paraprofessionals, and other service providers) may have access to and make entries into the client's record, the psychologist has less direct control over the record. Psychologists are encouraged to participate in development and refinement of organizational policies involving record keeping.

It is important to note that multidisciplinary records may not enjoy the same level of confidentiality generally afforded psychological records. The psychologist working in these settings is encouraged to be sensitive to this wider access to the information and to record only information congruent with organizational requirements and necessary to accurately portray the services provided. In this situation, if permitted by institutional rules and legal and regulatory requirements, the psychologist may keep more sensitive information, such as therapy notes, in a separate and confidential file.[10]

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[8] The reader may wish to consult the HIPAA Security Rule for further guidance on this issue.

[9] See the HIPAA Security Rule.

[10] In order for therapy notes to have heightened protection as "psychotherapy notes" as defined by the HIPAA Privacy Rule, the notes must be kept separate from the rest of the record. If they are psychotherapy notes, only the psychologist who took the notes can access them, absent a HIPAA complaint authorization from the client (for more details regarding the Privacy Rule, see Standards for Privacy of Individually Identifiable Health Information, 2002).

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Guideline 11—Multiple Client Records: The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.

Rationale

In providing services to multiple clients, issues of record keeping may become very complex. Because records may include information about more than one individual client, legitimate disclosure of information regarding one client may compromise the confidentiality of other clients.

Application

The psychologist strives to keep records in ways that facilitate authorized disclosures while protecting the privacy of clients. In services involving multiple individuals, it may be important to specify the identified client(s) (Ethics Code, Standards 10.02 and 10.03).

There are a number of further concerns regarding record keeping with multiple clients. First, the information provided to clients as part of the informed consent process at the onset of the professional relationship (Ethics Code, Standard 10.02) may include information about how the record is kept (e.g., jointly or separately) and who can authorize its release. In considering the creation of records for couple, family, or group therapy, the psychologist may first seek to clarify the identified client(s). In some situations, such as group therapy, it may make sense to create and maintain a complete and separate record for all identified clients. On the other hand, if a couple or family is the identified client, then one might keep a single record. This will vary depending upon practical concerns, ethical guidelines, and third-party reporting requirements. Upon later requests for release of records, it will be necessary to release only the portions relevant to the party covered by the release. Given this possibility, the psychologist may choose to keep separate records on each participant from the outset. The psychologist endeavors to become familiar with legal and regulatory requirements regarding the release of a record containing information about multiple clients.

Guideline 12—Financial Records: The psychologist strives to ensure accuracy of financial records.

Rationale

Accurate and complete financial record keeping helps to ensure accuracy in billing (Ethics Code, Standards 6.04 and 6.06). A fee agreement or policy, although not explicitly required for many kinds of psychological services such as preemployment screening under agency contract or emergency counseling services at a disaster site, provides a useful starting point in most service delivery contexts for documenting reimbursement of services. Accurate financial records not only assist payers in assessing the nature of the payment obligation but also provide a basis for understanding exactly which services have been billed and paid. Up-to-date record keeping can alert the psychologist and the client to accumulating balances that, left unaddressed, may adversely affect the professional relationship.

Application

Financial records may include, as appropriate, the type and duration of the service rendered, the name of the client, fees paid for the service, and agreements concerning fees, along with date, amount, and source of payment received. Special consideration may be given to fee agreements and policies, barter agreements, issues relating to adjusting balances, issues concerning copayments, and concerns about collection.

Fee agreement or fee policy. The financial record for services may begin with a fee agreement or fee policy statement that identifies the amount to be charged for service and the terms of any agreement for payment. The record may potentially include who is responsible for payment, how missed appointments will be handled, acknowledgement of any third-party payer preauthorization requirements, any agreement regarding copayment and adjustments to be made, payment schedule, interest to accrue on unpaid balance, suspension of confidentiality when collection procedures are employed, and the methods by which financial disputes may be resolved (Ethics Code, Standard 6.04).

Barter agreements and transactions. Accurately recording bartering agreements and transactions helps ensure that the record clearly reflects how the psychologist was compensated. Designation of the source, nature, and date of each financial or barter transaction facilitates clarification when needed regarding the exchange of goods for service. Because of the potential for the psychologist to have greater power in the negotiation of bartering agreements, careful documentation protects both the psychologist and the client. Such documentation may reflect the psychologist's basis for concluding, at the onset, that the arrangement is neither exploitative nor clinically contraindicated (Ethics Code, Standard 6.05).

Adjustments to balance. It is helpful to designate the rationale for, description of, and date of any adjustments to the balance that are made as a result of agreement with a third-party payer or the client. This may reduce potential misunderstanding or perceived obligations that might affect the relationship.

Collection. Psychologists may consider including in the record information about collection efforts, including documentation of notification of the intention to use a collection service.

Guideline 13—Disposition of Records: The psychologist plans for transfer of records to ensure continuity of treatment and appropriate access to records when the psychologist is no longer in direct control, and in planning for record disposal, the psychologist endeavors to employ methods that preserve confidentiality and prevent recovery.[11]

Rationale

Client records are accorded special treatment in times of transition (e.g., separation from work, relocation, death). A record transfer plan is required by both the Ethics Code (Standard 6.02), and by laws and regulations governing health care practice in many jurisdictions. Such a plan provides for continuity of treatment and preservation of confidentiality. Additionally, the Ethics Code (Standards 6.01 and 6.02) requires psychologists to dispose of records in a way that preserves their confidentiality.

Application

The psychologist has two responsibilities in relation to the transfer and disposal of records. In anticipation of unexpected events, such as disability, death, or involuntary withdrawal from practice, the psychologist may wish to develop a disposition plan in which provisions are made for the control and management of the records by a trained individual or agency. In other circumstances, when the psychologist plans in advance to leave employment, close a practice, or retire, similar arrangements may be made or the psychologist may wish to retain custody and control of client records.

In some circumstances, the psychologist may consider a method for notifying clients about changes in the custody of their records. This may be especially important for those clients whose cases are open or who have recently terminated services. The psychologist may consider including in the disposition plan, in accordance with legal and regulatory requirements, a provision for providing public notice about changes in the custody of the records, such as placing a notice in the local newspaper.

Considerations of record confidentiality are critical when planning for disposal of records. For example, in transporting records to be shredded, the psychologist may take care that confidentiality of the records is maintained. Some examples of this effort might be accompanying the records through the disposal process or establishing a confidentiality agreement with those responsible for records disposal. When considering methods of record destruction, the psychologist seeks methods, such as shredding, that prevent recovery. Disposal of electronic records poses unique challenges because the psychologist may not have the technical expertise to fully delete or erase records, for example, before disposing of a computer hard drive, external back-up storage device, or other repository for electronic records. Even though efforts to delete or erase records may be undertaken, the records may nevertheless remain accessible by those with specialized expertise. The psychologist may seek consultation from technical consultants regarding adequate methods for destruction of electronic records, such as physically destroying the entire medium or wiping clean (demagnetizing) the storage device.[12]

Conclusion

These "Record Keeping Guidelines" provide a framework for keeping, maintaining, and providing for the disposition of records and what is contained in them. They discuss special situations: electronic records, organizational settings, and multiple clients. They are intended to benefit both the psychologist and the client by facilitating continuity and evaluation of services, preserving the client's privacy, and protecting the psychologist and client in legal and ethical proceedings.

These guidelines do not establish rules for practice, but rather provide an overall conceptual model and strategies for resolving divergent considerations. The demands of professional settings are varied and complex. It would not be feasible to establish detailed guidelines for record creation, maintenance, and disposition that would be relevant for each setting. The current document may provide useful guidance for various professional applications. Where standards and legal and regulatory codes exist, they take precedence over these guidelines.

Record Keeping Guidelines Bibliography

The authors considered the following reference materials and relied upon those with obvious authority (for example, the APA Ethics Code and HIPAA) while also consulting those that provided relevant guidance (APA guidelines; professional publications). This is not an exhaustive list of sources that psychologists may find useful in determining the best course of action in record keeping, and it is not intended to be representative of the entire body of knowledge that can guide decision making. It does represent, however, a solid basis for consideration that, in combination with state and federal regulations, may provide an adequate framework for record keeping.

[11] See the HIPAA Security Rule.

[12] See the HIPAA Security Rule requirements for the disposal of electronic records.

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Record Keeping Practices: More is More

Allan M. Tepper, J.D., Psy.D.

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Record keeping is an essential part of professional practice. It is a mandated requirement, and it is an integral component in providing good clinical care. Overall, the details of the treatment session, as well as the interventions instituted during treatment, should be documented in a clear, concrete manner.

Many mental health professionals are hesitant to record treatment sessions in a detailed manner. Often, there is a fear that the greater the detail, the higher the probability that harm will come to the patient or to the therapist. This hesitation often results in a *less is more* approach to record keeping.

In a legal setting, however, this minimal approach to record keeping can result in greater legal exposure of the mental health professional. That is, if the professional is required to defend the treatment in question, it is difficult to explain why pertinent information is missing from the written record. In this regard, consideration should be given to adopting a *more is more* approach to record keeping.

The written record should tell the story of treatment. The reader should be able to understand the issues being discussed, the interventions being instituted, and the reactions of the patient. For example, if clinical terms are used, there also should be a description of the

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patient's behavior. There is nothing wrong with stating that the patient appeared depressed. This observation, however, should be supplemented with specific detail and information. The treating professional may know when the patient presents in a depressed manner, but the details of this behavior must be conveyed to the reader in a transparent and concrete manner.

In high risk situations, such as a situation in which a patient is voicing suicidal ideation, the problem-solving steps considered and instituted by the treating professional should be recorded in a clear manner. Once again, a *more is more* approach should govern the record keeping practices. The record should clarify the patient risk factors; the record should identify the possible treatment interventions; the record should describe why the professional chose one intervention over another; the record should describe consultations with outside professionals; and the record should indicate what follow-up procedures were employed. Often, it is helpful to include patient quotes as part of the documentation process.

If the intervention is successful, and the threat of suicide subsides, this observation should be noted in follow-up session notes. If self-destructive impulses re-emerge during treatment, these feelings should be noted in the written record, as well as documenting the steps instituted to address the renewed suicidal ideation.

Overall, the concept of continuity of care should govern all record keeping practices. Record keeping provides continuity of care for the current provider, as well as providing a guidepost for the future provider.

Record keeping practices should not be overshadowed by the fear that someone might understand what occurred during treatment. In addition, from a risk management viewpoint, good record keeping often can serve as an aide in advocating for an early discharge of any alleged wrongdoing. For this reason, mental health professionals should consider the *more is more* approach to record keeping.

Clear, concrete, comprehensive session notes tell the story of treatment. Comprehensive records, coupled with the professional's training, expertise, and oral testimony, can show that proper care was provided to the patient. Comprehensive record keeping, therefore, is an integral component in providing good clinical care.

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Service Commission addressed matters which were *not* essential to the issue decided by the unemployment compensation referee.

The unemployment compensation referee's decision does not satisfy the third prong necessary for estoppel, in other words that the matters at issue in the first adjudication were not essential to the second adjudication. The Commission did not err in finding that the Correctional Institution met its burden of proving just cause to remove Morrison from his position as a corrections officer. After scrutiny, it is clear that there was no estoppel. Accordingly, we affirm the Commission's order.

ORDER

AND NOW, this 22nd day of May, 1995, the order of the State Civil Service Commission in the above-captioned matter is affirmed.

Polly ROST, Petitioner,

v.

STATE BOARD OF PSYCHOLOGY, Respondent.

Commonwealth Court of Pennsylvania.

Argued Feb. 9, 1995.

Decided May 22, 1995.

Clinical psychologist appealed from order of the State Board of Psychology, No. 0023–63–93, imposing reprimand. The Commonwealth Court, No. 1093 C.D. 1994, Doyle, J., held that: (1) psychologist breached duty of confidentiality, which also constituted unprofessional conduct, by releasing client records pursuant to subpoena without seeking consent of client, professional legal advice, or imprimatur of judge, even though it was ultimately determined in client's lawsuit that she had waived privilege of confidentiality; (2) confidentiality requirements of statute and regulation are not void for vagueness; and (3) there was no exception to confidentiality requirement on theory of "imminent danger" to individual or society based on psychologist's claim that client's lawsuit was fraudulent.

Affirmed.

1. Physicians and Surgeons ⇐11.3(5)

Commonwealth Court's review of decision of the State Board of Psychology reprimanding psychologist was limited to determination of whether constitutional rights had been violated, whether error of law was committed, and whether necessary findings of fact were supported by substantial evidence. 2 Pa.C.S.A. § 704.

2. Physicians and Surgeons ⇐15(9)

Psychologist violated requirement of confidentiality of client information, and thereby also engaged in unprofessional conduct, by releasing client's records pursuant to subpoena in client's lawsuit without consulting with client or her attorney, though client was ultimately found to have waived her right to confidentiality by initiating lawsuit in which her psychological condition was at issue. 63 P.S. § 1208(a)(9, 11).

3. Witnesses ⇐219(1)

Psychologist-client privilege may be waived by client, which may occur where client places confidential information at issue in case or where there is no longer expectation of privacy regarding the information because client has made it known to third persons. 42 Pa.C.S.A. § 5944.

4. Physicians and Surgeons ⇐15(17.1)

Code of ethics for psychologists imposes duty of confidentiality which extends beyond the testimonial privilege found in the judicial code; duty imposed under code of ethics is absolute and cannot be waived except after full disclosure and written authorization by client, and continues even when information has been previously disclosed to third parties or is material to litigation initiated by the client. 42 Pa.C.S.A. § 5944; 63 P.S. § 1208(a)(9).

5. Physicians and Surgeons ⇐2, 15(17.1)

Language of judicial code and of ethical principle of regulations of the State Board of Psychology, providing for confidentiality of all client information obtained in psychologist's practice except where client has given written permission to release the information or there is risk of imminent danger to another individual or society is not void for vagueness, even though psychologist may have in fact been confused by conflicting obligations imposed by the rules of her profession and a court-issued subpoena. 42 Pa.C.S.A. § 5944; 63 P.S. § 1208(a)(9); 49 Pa. Code § 41.61.

6. Physicians and Surgeons ⇐11.2

Though psychologist may have been placed in unfavorable position by receiving subpoena for client information, she was not excused from ethical guidelines of her profession forbidding disclosing of client's records without consent, and if she was uncertain about legal rights and responsibilities, she should at least have obtained advice from attorney instead of unilaterally releasing client's records. 63 P.S. § 1208(a)(9); 49 Pa. Code § 41.61.

7. Physicians and Surgeons ⇐11.2

Ethical principle of the regulations of the State Board of Psychology, permitting disclosure of client records when there is clear and imminent danger to individual or to society, did not permit psychologist to release client's records to defendant in suit by client which psychologist claimed was fraudulent; confidentiality exception applies only where client poses serious threat of killing or physically injuring third person or group of persons. 49 Pa. Code § 41.61.

James A. Bolden, for petitioner.

Jackie Wiest Lutz, for respondent.

Before DOYLE and SCHULTZ NEWMAN, JJ., and DELLA PORTA, Senior Judge.

DOYLE, Judge.

Polly Rost, a clinical psychologist licensed to practice in the Commonwealth of Pennsylvania, appeals from an order of the State Board of Psychology which reprimanded her for having violated Sections 8(a)(9) and (11) of the Professional Psychologists Practice Act (Act).[1] We affirm.

The facts in this case are not in dispute, having been stipulated to by the parties. This case originated in February of 1987 when an unlicensed supervisee of Rost began giving psychological treatment to S.P., a female juvenile. S.P. was treated in Rost's practice for recurring headaches that allegedly were caused when S.P. fell and struck her head at the York Jewish Community Center (YJCC). In March of 1988, S.P.'s mother filed suit against the YJCC on S.P.'s behalf, alleging that YJCC's negligence had caused her daughter physical and emotional harm.

In December of 1989, YJCC's attorney mailed Rost a subpoena requesting the treatment records for S.P. Rost subsequently provided YJCC with these treatment records. Although S.P.'s mother had previously signed a release allowing Rost to turn over the records to S.P.'s own attorney, Rost had not obtained permission to release the records to YJCC. Furthermore, Rost did not attempt to contact S.P.'s mother, or S.P.'s attorney, to obtain permission to release the records or to advise them of her intention to release the records prior to doing so. Rost did not attempt to gain permission because she believed that she was already authorized to release records to YJCC based upon the release which had previously been given to S.P.'s attorney.

On January 25, 1993, the Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs (BPOA) issued an order to show cause in which it charged Rost with having violated three sections of the Act: (1) Section 8(a)(9) of the Act[2] through her violation of Ethical Principle 5 of the Board Regu-

1. Act of March 23, 1972, P.L. 136, *as amended*, 63 P.S. § 1208(a)(9) and (11).

2. Section 8(a)(9) authorizes the board to suspend, revoke, limit or restrict a license or reprimand a licensee for "[v]iolating a lawful regulation promulgated by the board, including, but not limited to, ethical regulations....." 63 P.S. § 1208(a)(9).

lations [3] governing the confidentiality of client information; (2) Section 8(a)(13) of the Act [4] by failing to perform a statutory obligation imposed upon licensed psychologists; [5] and (3) Section 8(a)(11) of the Act [6] by engaging in unprofessional conduct.

[1] On June 17, 1993, a hearing was held before Frank C. Kahoe, a hearing examiner appointed by the Board. Subsequently, on August 30, 1993, the hearing examiner issued a proposed adjudication and order in which he concluded that Rost was not subject to disciplinary action under Section 8(a) of the Act, because S.P. had waived the client-psychologist privilege by asserting a claim for emotional damages in her lawsuit against YJCC. In response, the BPOA filed a brief on exceptions. The Board disagreed with the hearing examiner's recommendation, and by an amended order dated April 18, 1994,[7] officially reprimanded Rost for having violated Section 8(a)(9) and (11) of the Act.[8] Rost's appeal to this Court followed.[9]

On appeal, Rost presents the following questions for our review: (1) whether Rost violated Sections 8(a)(9) and (11) of the Act by releasing confidential medical records when she did so in response to a valid subpoena and where her client had previously authorized the release of the same records to the client's attorney; (2) whether the Board improperly found that Rost violated Sections 8(a)(9) and (11) of the Act since Ethical Principle 5 of the Board Regulations, upon which the Board's findings were based, is void for vagueness; and (3) whether Rost was exempted by Ethical Principle 5 of the Board Regulations from her duty to not release the records and thereby did not violate Sections 8(a)(9) and (11) of the Act.

[2] Rost's first argument is that she did not violate Sections 8(a)(9) and (11) of the Act because she released the records pursuant to a subpoena and S.P. waived her right to confidentiality by initiating a lawsuit in which her psychological condition was at issue. In support of this position, Rost points out that the trial court in S.P.'s lawsuit against YJCC ultimately ruled that S.P. had waived her privilege of confidentiality. (Respondent's Exhibit C, Reproduced Record (R.R.) 5d.) She further claims that S.P.'s attorney had a duty to disclose the records to YJCC during discovery. Accordingly, Rost argues that she did not violate Ethical Principle 5 of the Board Regulations, since S.P. no longer had an expectation of privacy in regard to the records.

However, we must agree with the Board that Rost's argument is misplaced. We are

3. 49 Pa.Code § 41.61. Ethical Principle 5(a) reads in pertinent part:

> Psychologists may not, without the written consent of their clients or the client's authorized legal representative, or the client's guardian by order as a result of incompetency proceedings, be examined in a civil or criminal action as to information acquired in the course of their professional service on behalf of the client. Information may be revealed with the consent of the clients affected only after full disclosure to them and after their authorization....

4. 63 P.S. § 1208(a)(13).

5. Section 5944 of the Judicial Code, 42 Pa.C.S. § 5944, states:

> No psychiatrist or person who has been licensed ... to practice psychology shall be, without the written consent of his client, examined in any civil or criminal matter as to any information acquired in the course of his professional services in behalf of such client. The confidential relations and communications between a psychologist or psychiatrist and his client shall be on the same basis as those provided or prescribed by law between an attorney and client.

6. 63 P.S. § 1208(a)(11).

7. An original order had been entered on March 29, 1994, which incorrectly stated that Rost had been found to have violated Section 8(a)(13) of the Act.

8. Although authorized to suspend or revoke Rost's license under Section 8(a) of the Act, as well as impose a one thousand dollar fine for each count under Section 11 of the Act, 63 P.S. § 1211, the Board chose to impose only a reprimand, the least burdensome penalty available.

9. Our review of the Board's decision is limited to a determination of whether constitutional rights have been violated, whether an error of law has been committed, and whether necessary findings of fact are supported by substantial evidence. Section 704 of the Administrative Agency Law, 2 Pa.C.S. § 704; *see Makris v. Bureau of Professional and Occupational Affairs*, 143 Pa.Commonwealth Ct. 456, 599 A.2d 279 (1991).

not faced with the question of whether YJCC should have been barred from introducing S.P.'s records at trial based on the psychologist-client privilege. That is a determination properly made by a judge and not by a psychologist lacking formal legal training. *See Moore v. Bray*, 10 Pa. 519 (1849); *Commonwealth v. Hess*, 270 Pa. Superior Ct. 501, 506, 411 A.2d 830, 833, *appeal dismissed as improvidently granted*, 499 Pa. 206, 452 A.2d 1011 (1979) (no claimant of a testimonial privilege can be the final arbiter of his own claim). At the time Rost released S.P.'s records to YJCC, she did not seek the consent of her client, professional legal advice or the imprimatur of a judge. Rather, she unilaterally decided to release S.P.'s records.

[3] Rost is also mistaken when she attempts to equate the psychologist-client privilege with the rule of confidentiality found in the Code of Ethics for psychologists. Although the two are similar, the privilege is limited in scope to the question of admissibility of evidence in a civil or criminal trial. In interpreting the psychologist-client privilege, we are guided by the same rules that apply to the attorney-client privilege. *Kalenevitch v. Finger*, 407 Pa.Superior Ct. 431, 595 A.2d 1224 (1991). The privilege may be waived by the client as was ultimately found to have occurred in this case.[10] Waiver of the privilege may occur where the client places the confidential information at issue in the case. *Premack v. J.C.J. Ogar, Inc.*, 148 F.R.D. 140 (E.D.Pa.1993). It may also be waived where there is no longer an expectation of privacy regarding the information because the client has made it known to third persons. *See Commonwealth v. Goldblum*, 498 Pa. 455, 447 A.2d 234 (1982) (attorney-client privilege no longer exists where communications were publicly disclosed by direction of client.)

[4] Nevertheless, the Code of Ethics for psychologists imposes a duty of confidentiality which extends beyond the testimonial privilege found in Section 5944 of the Judicial Code;[11] this duty is absolute and cannot be waived except after full disclosure and written authorization by the client. Unlike the privilege, it continues even when the information has been previously disclosed to third parties or is material to litigation initiated by the client. In the present case, Rost did not even attempt to obtain the consent of her client before releasing confidential information. Although S.P. was eventually found to have waived the psychologist-client privilege, this does not absolve Rost from her ethical duty of confidentiality. Rost had a duty to either obtain written permission to release the records from S.P. or challenge the propriety of the subpoena before a judge. Rost did neither. Instead, she unilaterally gave S.P.'s records to YJCC without consulting with S.P. or her attorney. Since the language of Ethical Principle 5 of the Board Regulations unambiguously prohibits this

> The principle of confidentiality is given effect in two related bodies of law; the attorney-client privilege ... in the law of evidence and the rule of confidentiality established in professional ethics. The attorney-client privilege applies in judicial and other proceedings in which a lawyer may be called as a witness or otherwise required to produce evidence concerning a client. The rule of client-lawyer confidentiality applies in situations other than those where evidence is sought from the lawyer through compulsion of law. The confidentiality rule applies not merely to matters communicated in confidence by the client but also to all information relating to the representation, whatever its source....

We believe this language applies equally well to a comparison of the psychologist-client privilege and a psychologist's duty of confidentiality embodied in Ethical Principle 5 of the Board Regulations.

10. Section 5944 of the Judicial Code, 42 Pa.C.S. § 5944, governing the psychologist-client privilege, does not expressly mention "waiver." However, it does state that the confidential communications between psychologists and their clients will be treated in the same way as under the attorney-client privilege. Furthermore, Section 5916 of the Judicial Code, 42 Pa.C.S. § 5916, governing the attorney-client privilege in civil matters, and Section 5928, 42 Pa.C.S. § 5928 of the Judicial Code, governing the privilege in criminal matters, both state that the privilege may be "waived." Therefore, the waiver principle is applicable to the psychologist-client privilege.

11. In addition to looking at the clear and unambiguous language of Ethical Principle 5 of the Board Regulations, we find Rule 1.6 of the *Pennsylvania Rules of Professional Conduct* to be helpful in determining the scope of the Board Regulations. The Comment to Rule 1.6 reads in pertinent part:

type of conduct, we must concur with the Board's conclusion that Rost violated Section 8(a)(9) of the Act. Additionally, we agree with the Board that Rost's breach of her duty of confidentiality constitutes unprofessional conduct in violation of Section 8(a)(11) of the Act.

[5] Rost's second argument is that the Board improperly found that she violated Section 8(a)(9) and (11) of the Act by releasing the medical records since Ethical Principle 5 of the Board Regulations is void for vagueness. Rost argues that the language of Section 5944 of the Judicial Code and Ethical Principle 5 of the Board Regulations is vague because it does not sufficiently inform a psychologist who is issued a subpoena as to how to comply with his or her ethical obligations without violating a court order. Therefore, Rost claims Ethical Principle 5 of the Board Regulations is invalid. Rost concludes that the Board could not properly find that she violated a Board regulation or engaged in unprofessional conduct based on a violation of an invalid regulation.

We strongly disagree with Rost's argument. Ethical Principle 5 provides for the confidentiality of all client information obtained in a psychologist's practice except where the client has given his written permission to release the information or where there is a risk of imminent danger to another individual or society.[12] Its language is not vague; rather, it is plain and unambiguous. Rost may in fact have been confused by the conflicting obligations imposed by the rules of her profession and a court issued subpoena. However, any confusion which she might have had cannot be attributed to the clear prohibition against revealing confidential information contained in Ethical Principle 5 of the Board Regulations.

[6] Whenever a professional in possession of confidential information is served with a subpoena, a conflict naturally arises between one's duty to the courts and one's duty of confidentiality towards one's client. In this respect, Rost is no different from the numerous other psychologists, doctors, lawyers, and clergymen who receive subpoenas in this Commonwealth each year. The value of a psychologist's, or other professional's, duty of confidentiality would be illusory if it could be overridden anytime a conflicting duty arose which was thought to be more important. Although Rost may have been placed in an unfavorable position, she is not excused from following the ethical guidelines of her profession which plainly forbid her from disclosing a client's records without her consent.

Rost argues that it is unreasonable to expect a psychologist, lacking formal legal training, to know the proper procedure to follow after receiving a subpoena. Rost apparently believes that she was in an untenable position in which she would have had to either violate the rules of professional conduct or disregard a subpoena. However, this argument is flawed. Rost could have challenged the subpoena in court or obtained permission from her client before releasing the information. If Rost was uncertain about her legal rights and responsibilities, she should have at least obtained advice from an attorney instead of unilaterally releasing her client's records. As a licensed psychologist, she had an obligation to be aware of the

12. Ethical Principle 5(b)(1) of the Board Regulations, 49 Pa.Code § 41.61, states:

> (b) A psychologist may reveal the following information about a client:
>
> (1) Information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities. The Code of Ethics does not prohibit a psychologist from taking reasonable measures to prevent harm when a client has expressed a serious threat or intent to kill or seriously injure an identified or readily identifiable person or group of people and when the psychologist determines that the client is likely to carry out the threat or intent. Reasonable measures may include directly advising the potential victim of the threat or intent of the client. Because these measures should not be taken without careful consideration of clients and their situation, consultation with other mental health professionals should be sought whenever there is time to do so to validate the clinical impression that the threat or intent of harm is likely to be carried out.

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ethical duties which govern her profession. Having received the benefits of being licensed by the state, Rost cannot now argue that she is a "layman" who lacks the knowledge and training necessary to understand and comply with the Board's regulations.[13]

[7] Rost's third argument is that her actions in releasing the medical records fall under the exception to Ethical Principle 5 of the Board Regulations which permits disclosure "when there is clear and imminent danger to an individual or to society."[14] 49 Pa.Code § 41.61. Rost argues that S.P.'s suit against YJCC was fraudulent and thereby created an "imminent danger" to YJCC and the Court of Common Pleas of York County. Only by releasing this information, Rost claims, was she able to prevent the danger "caused by fraudulent pleadings to the Commonwealth's Courts." (Petitioner's Brief, at 18.)

We may summarily dismiss this argument. The exception relied upon by Rost is very limited and does not encompass her situation. It only applies where a client poses a serious threat of killing or physically injuring a third person or group of persons. 49 Pa.Code § 41.61. While we condemn the filing of fraudulent pleadings,[15] it does not rise to the same level as serious physical harm. In this case, Rost does not allege that S.P. posed a threat of physical harm to others of any kind. Therefore, we agree with the Board that Rost's actions do not fall within any exception to Ethical Principle 5 of the Board Regulations.

Accordingly, we affirm the order of the Board which reprimanded Rost for having violated Sections 8(a)(9) and (11) of the Act.

13. Rost also argues that the attorneys for S.P. and YJCC failed to fully comply with the rules of discovery and that she would not have released the information as she did if they had acted properly. However, we do not need to decide whether Rost's allegations are correct since the attorneys' behavior is not relevant to our assessment of Rost's conduct. Even if the attorneys acted unprofessionally, this would not excuse Rost's own unprofessional conduct.

14. *See supra* note 12.

ORDER

NOW, May 22, 1995, the order of the State Board of Psychology in the above-captioned matter is hereby affirmed.

George M. SIMON and Eugene P. Weisman, Petitioners,

v.

COMMONWEALTH of Pennsylvania, Respondent.

Commonwealth Court of Pennsylvania.

Argued Dec. 6, 1994.
Decided May 22, 1995.

Petitioners sought declaratory and injunctive relief against Pennsylvania crime commission based on inclusion of their names and report on connection between organized crime and bingo industry prior to giving notice to petitioners. The Commonwealth Court, No. 205 M.D. 1993, Kelley, J., held that: (1) right to reputation was fundamental right under Pennsylvania Constitution; (2) fact that crime commission had investigatory purpose did not justify abrogation of right to process and right to protect reputations; and (3) right of citizen to preserve constitutionally protected reputation outweighed interests of Commonwealth in proceeding without constitutional guaranty of due process so that notice was required before results of investigation could be disseminated to public.

15. We point out that there is nothing in the record before us which would support Rost's contention that S.P.'s pleadings were in fact fraudulent. Therefore, even if Rost's argument had merit on its face, we would have to dismiss it since it is not factually supported in the record. *See Churilla v. Barner*, 269 Pa.Superior Ct. 100, 105 n. 6, 409 A.2d 83, 86 n. 6 (1979) ("allegations of a pleading do not constitute part of a trial record unless made part of it by offer and admission or court direction").

Response to a Subpoena Revisited

Allan M. Tepper, J.D., Psy.D., Legal Consultation Plan

At times, a psychologist may receive a subpoena requesting notes; raw testing data; reports; or other items relating to a past or present patient. The psychologist may be requested to furnish these items to an attorney or to a copying service engaged by the attorney. Despite the anxiety often generated by the receipt of such a subpoena, a non-emotional response to this records request can help avoid future ethical difficulties. This article will review the legal and practice considerations associated with the receipt of a records subpoena.

In *Rost v. State Board of Psychology* (1995), the Commonwealth Court of Pennsylvania (the appellate court that reviews State Board of Psychology decisions) upheld a State Board of Psychology decision in which a psychologist was found to have violated the Professional Psychologists Practice Act for having responded to a validly issued subpoena without first contacting the patient or the supervising Court. In essence, the *Rost* decision held that it is unethical for a psychologist to release a patient's records without first obtaining the consent of the patient or a Court order.

In *Rost*, the psychologist received a defense subpoena for treatment records associated with a negligence action in which the plaintiff/patient was claiming emotional harm. At the time of the receipt of the defense subpoena, the psychologist possessed written permission from the patient to release the patient's records to the patient's attorney. At the time of the receipt of the defense subpoena, the psychologist did not have written permission from the patient to release the patient's records to the defense attorney. Relying upon the release directed towards the patient's attorney, the psychologist complied with the defense subpoena and forwarded the records to the defense attorney.

In upholding a finding of unprofessional conduct by the psychologist, the Commonwealth Court stated that the confidentiality requirement found in the State Code of Ethics for psychologists is absolute and cannot be waived except after full disclosure and written permission by the client (page 629). Thus, despite the issuance of a valid subpoena, the psychologist had a duty to either obtain written permission from the patient to release the records or challenge the propriety of the subpoena before a judge (page 629).

> Whenever a professional in possession of confidential information is served with a subpoena, a conflict naturally arises between one's duty to the Court and one's duty of confidentiality towards one's client. In this respect, Rost is no different from the numerous other psychologists, doctors, lawyers, and clergymen who receive subpoenas in this Commonwealth each year. The value of a psychologist's, or other professional's duty to confidentiality would be illusory if it could be overwritten anytime a conflicting duty arose which was thought to be more important. Although Rost may have been placed in an unfavorable position, she is not excused from following the ethical guidelines of her profession which plainly forbid her from disclosing a client's records without her consent (page 630).

In essence, *Rost* requires that upon receipt of a validly executed subpoena, a psychologist may not release a patient's records without first obtaining the written consent of the patient or receiving additional instruction from the supervising judge. Unilaterally responding to the subpoena shall be deemed to be unprofessional conduct.

In reality, this requirement is not an overwhelming burden and does not differ extensively from the practice advocated prior to the *Rost* decision. That is, upon the receipt of a records subpoena, it is advisable that the psychologist contact both attorneys, in writing, notifying them that the psychologist has received the subpoena. This correspondence should state that given the ethical considerations surrounding this records subpoena, the psychologist is requesting written permission from the patient allowing the psychologist to comply with the records request. This correspondence should state further that if no such written permission is forthcoming, the psychologist shall await further instruction from the supervising judge.

This type of written correspondence accomplishes a number of goals. First, it places the psychologist in compliance with *Rost* in that the psychologist is maintaining the confidentiality of the record while also acknowledging the issuance of the subpoena. Second, it shifts the burden associated with this records request to the attorney. That is, the attorneys can either agree to the request or seek a court order from the supervising judge. The patient's attorney can seek a court order quashing the subpoena or requesting a protective order governing any objectionable parts of the record. The defense attorney can seek a court order compelling production of the records. Thus, although the Commonwealth Court in *Rost* correctly states that the psychologist himself or herself can file a court challenge to the issuance of the subpoena, it is advisable, if possible, for the psychologist to attempt to remove himself or herself from the conflict; request that the attorneys agree to a resolution of the conflict; and, if no such resolution is possible, provide the psychologist with a court order stating whether or not the psychologist should comply with the subpoena. Once again, all such correspondence and requests to the attorneys should be conducted in writing, rather than being conducted

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Act 48 Credits Are Required

Gail Karafin, Ph.D.

On November 23, 1999, Governor Tom Ridge signed into law House Bill 8, better known as Act 48, delineating the requirements for maintaining an active professional educator's certificate. School Psychologists and Educational Specialists Levels I and II holding Pennsylvania certificates now need to comply with the regulations of Act 48 to remain certified, whether or not they are employed in public schools. This act reversed previous certificates that were considered permanent for ninety-nine years. Pennsylvania psychologists who hold school psychology certifications need to take Act 48 continuing education credits at the rate of 180 credit hours in a five-year period in order to maintain their active status with the Pennsylvania Department of Education.

This Act requires educators to complete six college credits in a five-year period (one credit is equivalent to thirty hours), or 180 hours of continuing education credits, or any combination of college studies and continuing education credits. These credit hours must be related to the educator's area of certification. This could include assessment, counseling/therapy, child or adolescent issues, mental health diagnoses and practices, family consultations, teacher training, curriculum, psychoactive pharmacology for children and adolescents, ethical/legal issues in school practices, behavior management, IEP/ER preparation, special education services, or any topic related to school-age children or educational practices. School psychologists certified prior to July 1, 2000, must obtain the 180 credit hours by June 30, 2005.

The Pennsylvania Department of Education maintains an ongoing record of each educator's Act 48 credits by his/her social security number. An agency must apply for approval to be a state professional education provider. These providers are responsible for reporting hours/credits to the PA Department of Education directly. Educators can monitor their credits by going to the PA Department of Education website and using their social security number to check the status of their credits. The PDE website is [www.pde.state.pa.us]. Information about Act 48 can also be found on the PATTAN website at [www.pattan.k12.pa.us] or by calling the Bureau of Curriculum and Academic Services at 717-772-4944. Most universities, school districts and intermediate units were approved to offer Act 48 credits.

The Pennsylvania Psychological Association (PPA) is an approved provider and can give both Act 48 credits for school psychologist certification as well as continuing education credits for licensing when attending our workshops and conferences. In addition, the Human Service Center (HSC) of the Philadelphia Society of Clinical Psychologists (PSCP) is an approved PDE provider. Both members and non-members can attend any of their workshops or lectures and receive continuing education credits and Act 48 credits. Furthermore, the HSC will certify Act 48 credits for programs given by non-PDE providers for a nominal fee. PPA also provides this service.

Response to a Subpoena

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over the telephone, so that the psychologist possesses a written record indicating the manner in which the psychologist was attempting to discharge his or her ethical and legal responsibilities.

In summary, prior to releasing confidential information, Pennsylvania psychologists are required to obtain written consent from their patients. Absent such written consent, confidential information may not be released to outside third parties. Upon receipt of a subpoena requesting confidential information, the psychologist must obtain the written consent of the patient or additional instruction from the supervising Court. The unilateral response to a subpoena without such patient permission or court instruction shall be considered a violation of the Professional Psychologists Practice Act.

Reference

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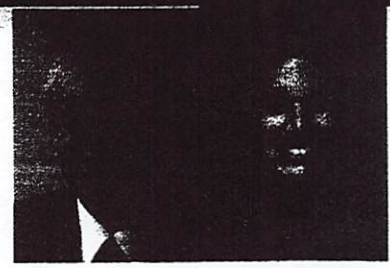

A MINDFULNESS Approach to a Response to a Subpoena

ALLAN M. TEPPER, JD, PsyD; *PPA Legal Consultation Plan*
SAMUEL KNAPP, EdD, ABPP; *Director of Professional Affairs*
RACHAEL L. BATURIN, MPH, JD; *Director of Government, Legal, and Regulatory Affairs*

Record keeping and maintaining confidentiality is an important part of clinical practice. At times, a request may be made for present or past patient records or in court oral testimony. Such requests must be reviewed in a careful, reasoned manner. Such requests must be addressed with regard to the applicable record release requirements. Such requests, however, need not cause undo anxiety or upset which then may result in a less reasoned response that is inconsistent with existing requirements.

Once records are generated, the clinician becomes the custodian of the records. The records, in essence, belong to the patient. That is, the clinician owns the paper or electronic device upon which the treatment information is housed. The actual information, however, belongs to the patient. Hence, the clinician is the custodian of the records.

In Pennsylvania, the general rule is that the written permission of the patient is necessary prior to the clinician having the authority to release records to an outside third party or testify in court. There are, however, exceptions to this general rule. These exceptions often result in undue upset and anxiety, or, at times, unnecessary fear that the release of the records will result in dire harm to the patient, the clinician, or other individuals. It is at this juncture that the clinician must be mindful of the requirements that govern such situations.

There are three broad categories from which the requirements governing clinical practice are derived: Statutes; Rules and Regulations; and Case Law.

Statutes are laws that are generated by the State legislature. Rules and regulations are promulgated by the licensing board. Case law constitute legal cases decided in the particular state in which the treatment is being rendered.

A subpoena is an official legal document often utilized by an attorney in a pending legal action. The subpoena is served upon the clinician and may request the production of records; oral tesimony; or both.

A subpoena is an official legal document often utilized by an attorney in a pending legal action. The subpoena is served upon the clinician and may request the production of records; oral testimony; or both.

Many clinicians are under the assumption that absent a Court Order, one may disregard a subpoena. In Pennsylvania, this assumption is false, and can result in unnecessary time, expense, and, possibly, disciplinary action against the clinician. In this regard, following the receipt of a subpoena, a timely response is required.

At this juncture, however, the response does not include the immediate release of the records or the rendering of oral testimony. Rather, in Pennsylvania, this situation is governed by *Rost v. State Board of Psychology* (659 A.2d 626), a Pennsylvania Commonwealth Court decision.

Pursuant to *Rost*, a subpoena alone is not sufficient to negate the need for the written patient authorization necessary to release records or testify in court. Rather, *Rost* requires that written authorization from the client, along with the subpoena, is necessary to comply with the subpoena. If no such written authorization is forthcoming, *Rost* states that a Court Order is necessary to negate the need for written patient authorization.

The importance of this case is that there will be many instances in which records are released or testimony will be rendered absent a Court Order. More specifically, as long as the clinician is in receipt of the subpoena and the written authorization executed by the patient, no overriding court

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to the preferences of patients to integrate religion and spirituality into psychotherapy. Nonetheless, it must be done in a manner that respects patient autonomy. Dr. Lemon is a great teacher (and co-author) and I have benefitted greatly from my collaboration with her.

Dr. Jeff Sternlieb and I will present on *Using Self-Reflection to Aid Our Decision-Making*. Our ability to act ethically can be undercut if we fail to be alert for our personal blind spots. The problem is that self-reflection does not always come naturally and sometimes it can be difficult. Dr. Sternlieb is a powerful presenter who brings a wealth of personal and professional experiences to these workshops as a psychologist, psychology-educator, and consultant.

Drs. Molly Cowan, Randy Fingerhut, Linda Knauss and I will be presenting a program on *Understanding the APA Ethics Code* for advanced practitioners. We have a few brief lectures intermixed with exercises where participants can think through real-life ethical issues and see how the Ethics Code can help them resolve the issues (or where they need additional resources besides the Ethics Code to resolve the issues). I am pleased to be doing this workshop with such an all-star cast of ethics presenters.

Dr. John Gavazzi, one of my all-time favorite presenters, is leading a workshop on *Ethical Decision-Making Models: Biases and Emotions*. Dr. Gavazzi combines years of practical experience and recent literature on decision making to help participants to better think through the difficult decisions that they often must make. Dr. Gavazzi will combine lecture and collaborative learning exercises using the realistic vignettes found on the Ethics and Psychology website. Dr. Gavazzi has told me that past workshop participants "have found collaborative learning and vignette analysis an enjoyable way to understand how their personal values intersect with professional obligations to create ethically appropriate decisions."

Finally, I am doing a workshop on *Advanced Risk Management: An Ethically Informed Approach*. This program shows ways that patients can be harmed (or at least perceive themselves to be harmed) and it demonstrates how psychologists can protect themselves from unfounded or frivolous complaints. Good risk management strategies are not driven by fear but are based on overarching ethical principles. The best risk management principle is to deliver and document good care and any purported risk management strategy that harms a patient or violates an overarching ethical principle needs to be reconsidered.

For those of you who are attending, Dr. Gavazzi's presentation on ethical decision making will be on Wednesday from 1:30 to 4:30; Dr. Lemon and my presentation on religion, spirituality, ethics, and religion will be Wednesday from 5 to 8 PM; Drs. Cowan, Fingerhut, Knauss' and my presentation on the APA Ethics Code will be on Thursday from 8:30 to 11:30; Dr. Sternlieb and my presentation on self-reflection will be on Friday from 1:30 to 4:30 and my presentation on risk management will be on Saturday from 1:15 to 4:15.

I look forward to seeing you at the convention for one or more of these workshops! We might learn something from each other and have fun in the process. What? Ethics fun? Really?

A MINDFULLNESS APPROACH TO A RESPONSE TO A SUBPOENA

order is required.

It should be noted that many practicing Pennsylvania attorneys are unaware of the *Rost* decision. For this reason, if a clinician receives a subpoena without the necessary written patient authorization, the clinician should respond in writing via a written letter to the requesting party outlining the status of the request for records or testimony. Without such a written response, the requesting party may file a Motion to Compel Production of the records or testimony, along with a request for attorney's fees and costs. For this reason, even if the clinician must obtain their own outside legal advice, the clinician should not respond to these Rost situations in an informal manner via a telephone call, an electronic email communication, or a cell phone text message.

Rather, it is preferable to utilize a clear, concrete, written letter outlining the initial response to the subpoena. Often, this type of letter will result in the requesting party obtaining the outstanding written patient authorization or the necessary overriding court order. At that juncture, the clinician, in their role as the custodian of the records, can comply with the request for records or testimony in a manner that is consistent with the requirements governing these situations.

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• Admitted in PA and NY
• Licensed Psychologist

November 18, 2022

Paula Martino, Esquire
33 Court Street
Legal, PA 84652

Max Antonio, Esquire
58 Brief Street
Pending, PA 98795

Re: **Subpoena Request for Records of Lucia Rose**

Dear Ms. Martino and Mr. Antonio:

I am writing in reference to the above-captioned matter. Once you have had an opportunity to review this letter, please advise if there are any questions.

On November 18, 2022, I received from Ms. Martino a copy of the attached subpoena request for records of Lucia Rose. Please note that pursuant to *Rost v. State Board of Psychology* (659 A.2d 626), a written consent from the patient or an overriding Court Order is required prior to the release of any confidential records.

I would appreciate it, therefore, if you could forward to me a copy of a written release from Ms. Rose providing me with permission to comply with the attached subpoena request for records. If no such written release is forthcoming, I shall await further instruction from the Court.

In advance, thank you for your time and cooperation in this matter.

Sincerely,

Allan M. Tepper, J.D., Psy.D.
Licensed Psychologist

cc: Lucia Rose

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E-mails, E-mails, E-mails: Boundaries, Boundaries, Boundaries

Allan M. Tepper, J.D., Psy.D., PPA Legal Consultation Plan
Samuel Knapp, Ed.D., Director of Professional Affairs
Rachael L. Baturin, MPH, J.D., Professional Affairs Associate

Many individuals routinely use electronic mail (e-mail). Once confined to the office computer, the sending and receipt of e-mail now can be accomplished in almost any setting, using laptop computers, mobile phones, and other electronic devices. The use of e-mails between a psychologist and a patient raises a number of personal, professional, and ethical concerns. This practice also raises clinical and record-keeping issues.

Currently, the Pennsylvania State Board of Psychology has no rules that address or prohibit the use of e-mails between a psychologist and a patient. It is necessary, therefore, to apply any existing rules and regulations when utilizing e-mail communication with a patient (Martin, 2010). In addition, any psychologist utilizing e-mail with a patient should establish a policy that governs this form of clinical interaction (Baturin, 2010).

Use of e-mail communication

E-mail communication is simple, fast, and efficient. It is an easy means of maintaining contact with others. Currently, there is a social expectation that despite the time of day or geographical location, there always is e-mail availability. Despite this widespread use of e-mail, it remains the professional responsibility of the psychologist to determine whether e-mail will be incorporated into the therapeutic relationship. There still are telephones, telephone answering machines, and answering services. Thus, despite the ease and social expectation of the use of e-mail communication, the psychologist must determine whether there is a professional basis to engage in e-mail communication with a patient.

Content of e-mail communication

If a psychologist decides to e-mail a patient, it is necessary to determine when e-mail will be used. That is, will the psychologist use e-mail for such logistical purposes as the scheduling or canceling of appointments? Conversely, will e-mail be utilized to transmit clinical information back and forth between the patient and the psychologist?

When deciding whether to utilize e-mail to transmit clinical information, the psychologist must determine the clinical appropriateness of conducting treatment in this manner. Usually, if a patient telephones a psychologist between sessions in a nonemergency situation, the psychologist advises the patient that it might be best to discuss the issue during the course of their next scheduled meeting. It would appear, therefore, that a similar approach would be prudent when receiving clinical e-mail communications from a patient, especially when treating a needy patient who requires greater structure.

Dr. Allan M. Tepper

Dr. Samuel Knapp

Rachael L. Baturin

Form of e-mail communication

Many e-mails conducted between friends are social and informal in nature. The use of first names, abbreviations, shortened sentences, bold face type, and irregular punctuation is a common occurrence. In order to ensure that boundaries are not blurred, one risk management recommendation is that psychologists abstain from the use of such informal language when e-mailing a patient. Once again, despite the everyday use of e-mail communication, the psychologist is in a professional relationship with the patient. The e-mail, therefore, should be professional in nature. In essence, the e-mail should resemble a professional letter, rather than appearing as an informal note between friends.

Timing of e-mail communication

Upon sending an e-mail, the sender often anticipates an immediate response. There is an expectation that most people read their e-mails promptly, and thus an immediate response will be forthcoming.

If the decision is made to e-mail a patient, the psychologist should discuss with the patient, in advance, the timing of the response to the patient's e-mail (Baturin, 2010). Once again, a telephone analogy is useful. Many psychologists, both private and agency-based, utilize a voice-mail message that advises the caller that the psychologist currently is unavailable, the psychologist will return to the office at a certain time, and the caller should proceed to a local emergency room if time is of the essence. Generally, there is no expectation that the psychologist will be checking telephone messages on a continuous 24-hour basis.

The psychologist also must be cognizant of the actual time at which an e-mail is forwarded to a patient. No one maintains the same personal or professional schedule. Many people work on their computers at different times of the day and night. Nonetheless, is it appropriate to respond to a patient after what generally is considered to be professional business hours? Would

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LEGAL COLUMN

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such a response instill in the patient an unfounded sense of feeling special to the psychologist? Is the psychologist overly involved in the care of the patient? The time the e-mail is sent, therefore, raises clinical and boundary issues.

Maintenance of e-mail communication

There is a question as to whether pursuant to 49 Pa. Code §41.57 (the Pennsylvania Psychology Licensing Board professional records regulation), an e-mail constitutes part of the patient's record. In general, a psychologist is not required to maintain a record of all brief telephone contacts with a patient. An argument can be made, therefore, that the failure to maintain a copy of a nonclinical e-mail with a patient does not constitute a record-keeping violation.

Despite this record-keeping issue, however, it is recommended for risk management purposes that a psychologist download, print, and maintain a copy of all e-mails received from and sent to a patient, except for brief scheduling communications. If the psychologist decides to use e-mail, it is likely the patient will maintain a copy of all e-mail correspondence. If the patient later alleges some type of wrongdoing by the psychologist, there is a greater likelihood that the patient may reveal only the e-mail communication that supports the patient's allegations. Thus, if e-mail communication is utilized during treatment, we recommend, for risk management purposes, placing a printed copy of the e-mail communication into the patient's file and maintaining it for the required 5-year record-keeping time period.

Discussion

Electronic mail (e-mail) communication is allowed between a psychologist and a patient. Currently, such communications are governed by existing rules and regulations. If a psychologist chooses to engage in e-mail communications with a patient, such communication should be conducted professionally, consistent with the clinical constellation of the patient, and maintained as part of the treatment record. Overall, when engaging in such e-mail communication, the psychologist must remain cognizant of the need to maintain firm structure and boundaries in the treatment relationship.

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Sustaining Members 2009-10

Special thanks to our Sustaining Members for the fiscal year that ended June 30! PPA appreciates your additional support. Sustaining Members contribute an extra $100 or more at the time of their dues renewal. Members' dues are due in the quarter in which they joined, so please look for the Sustaining Member notice with your dues statement. This program helps PPA maintain a strong organization with a balanced budget. For more information, please visit the PPA website, www.PaPsy.org. We raised $5,500 in the last fiscal year with this effort.

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