KSDE TASN School Mental Health Initiative Webinar Series

Ethical Recordkeeping in School Mental Health (Part 2)

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Presenter Information

Jim Raines calls himself an accidental academic with the heart of a practitioner. He earned his MSSW at Columbia University in New York City and his Ph.D. from Loyola University of Chicago. Jim has been President of the Illinois Association of School Social Workers, Midwest Council of School Social Workers, and the School Social Work Association of America. He has written four books published by Oxford University Press, including one on ethical decision-making with Nic Dibble in 2011. He has keynoted state, national, and international conferences. He is currently a Professor of Social Work at California State University Monterey Bay.

Learner Objectives

1. Participants will learn how records should be transmitted to others.
2. Participants will learn boundary issues related to using social media.
3. Participants will learn what information should be documented and what should not.
4. Participants will learn about the limitations to personal notes.
5. Participants will learn how and when to destroy client records following termination of services.

Ethical & Legal Issues

1. **Privacy** – What information should I collect? (How intrusive should I be?)
2. **Accuracy** – How objective should the information be?
3. **Confidentiality** – What information should I protect?
4. **Access** – Who should be able to read or review?
5. **Communication** – How should records be transmitted to others?
6. **Documentation** – What or how much information facilitates client services?
7. **Destruction** – How & when should information be destroyed?

Communication

Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an ***understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges*** (Sec. 1.04(d)).

Implications:

- Recognize that email does a very poor job of transmitting nonverbal and paraverbal cues, which are crucial when addressing emotional content.
- Recognize how easily electronic communication can be shared with others even if unintentionally.

Communication cont'd

Social workers should avoid communication with clients using technology (such as social networking sites, online chat, e-mail, text messages, telephone, and video) ***for personal or nonwork-related purposes*** (Sec. 1.06(e)).

Implications:

- Beware of boundary crossings and boundary violations.
- Use technology tools that protect your personal information (e.g., Remind or Google number), but check your LEA's social media policy.

Communication cont'd

Social workers should take reasonable steps to **protect the confidentiality of electronic communications**, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption, firewalls, and passwords) when using electronic communications such as e-mail, online posts, online chat sessions, mobile communication, and text messages (Sec. 1.07 (m)).

Implications:

- Avoid using Google docs to receive or send communication about a client (or referral) without safeguards.
- It can be encrypted and use a Duo identity confirmation system requiring our work password and a confirmation via cell phone.

Documentation

Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include ***only information that is directly relevant*** to the delivery of services (Sec. 3.04 (c)).

Implications:

- Just because the information is collected does *not* mean that it should go into the report.
- Consider having clients/parents read a draft of the report before it is finalized.

Documentation cont'd

Social workers should include **sufficient and timely documentation** in records to facilitate the delivery of services and to ensure continuity of services provided to the client in the future (Sec. 3.04 (b)).

Implications:

- Provide enough info for a substitute or successor to know where you left off and they can begin.
- Ensure that records are updated before you leave for the weekend.

FERPA on Educational Records

Includes records:

- Directly related to a student
- Maintained by an educational agency or institution or by a party acting for the agency or institution.

Does **NOT** include:

- Records made or maintained by a physician, psychiatrist, psychologist, or **other recognized professional** or paraprofessional acting in his professional capacity or assisting in a paraprofessional capacity;
- Made, maintained, or used only in connection with treatment of the student;
- Disclosed only to individuals providing the treatment.

FERPA on Educational Records

Does **NOT** include:

- Records which are kept in the sole possession of the maker of the records, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the records.
- Once the contents or information recorded in sole possession records is disclosed to any party other than a temporary substitute for the maker of the records, those records become education records subject to FERPA.

Personal Notes in Illinois

"A therapist… may, to the extent he determines it necessary and appropriate, keep personal notes regarding a recipient. Such personal notes are the work product and personal property of the therapist and shall not be subject to discovery in ***any judicial***, administrative, or legislative proceeding or any proceeding preliminary thereto."

– IL Mental Health & Developmental Disabilities Confidentiality Act

Content of Personal Notes

Means:

(i) information disclosed to the therapist in confidence by other persons on condition that such information would never be disclosed to the client or other persons;

(ii) information disclosed to the therapist by the recipient which would be injurious to the client's relationships to other persons, and

(iii) the therapist's speculations, impressions, hunches, and reminders.

- IL Mental Health & Developmental Disabilities Confidentiality Act

Personal Notes in IL

The record does *not* include the therapist's personal notes, *if* such notes are kept in the therapist's sole possession for his own personal use and are not disclosed to any other person, *except* the therapist's supervisor, consulting therapist or attorney. If at any time such notes are disclosed, they shall be considered part of the recipient's record for purposes of this Act.

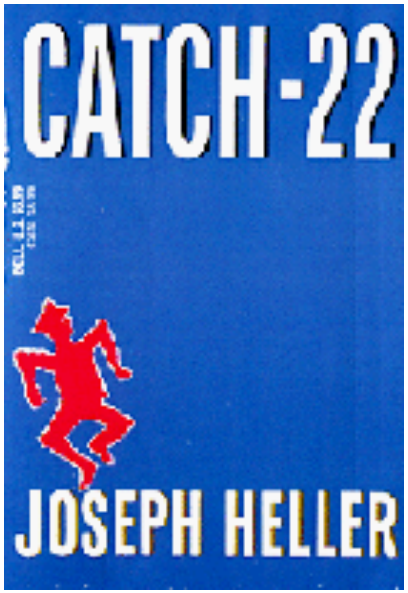
- IL Mental Health & Developmental Disabilities Confidentiality Act

Determination of "Personal Notes"

- States can permit *in camera* review to balance the interests of opposing parties.
- *Estate of Bagus* (Illinois Appellate Court, 1998) ruled it was permissible for the court to inspect personal notes to determine if they should be disclosed to opposing counsel.
- Thus, only a court of law can determine whether a note is truly "personal."

Double Dilemma

- Courts know about and expect good therapists to keep personal notes.
- Courts may want to review any personal notes and this action may turn them into public records.



HIPAA Regulations

Psychotherapy notes are:

- Recorded (in any medium) by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session;
- Separated from the rest of the client's medical record.

HIPAA Regulations

Psychotherapy notes don't include:

- medication prescription and monitoring,
- counseling session start and stop times,
- modalities and frequencies of treatment furnished,
- results of clinical tests, and
- any ***summary*** of the following items:
  - Diagnosis,
  - Functional status,
  - Treatment plan,
  - Symptoms,
  - Prognosis, and
  - Progress to date.

Protecting Clinical Notes

- Accord “personal notes” at least the **same protections** as the official record.
- Keep notes **separate from** official records that include medication monitoring, counseling session times, modality and frequency of treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Destruction of Records

Social workers should protect the confidentiality of deceased clients consistent with the preceding standards (Sec. 1.07 (r)).

Implications:

- Deceased clients deserve the same protections as living ones (e.g., Nicole Brown Simpson).
- Maintain records for the same length of time as you would living clients.

Destruction of Records

Social workers should transfer or dispose of clients' records in a manner that **protects clients' confidentiality** and is consistent with state statutes governing records and social work licensure (Sec. 1.07 (s)).

Implications:

- Use a cross-cut shredder to dispose of written records consistent w/ state laws.
- Destroy electronic records thoroughly by emptying your "recycle bin."
- Consider not only school student records law, but also the "statute of limitations" for personal injury.

Foundations of Malpractice

1. The defendant (professional) owes the plaintiff (client) a duty.
2. That defendant failed to perform or breached the duty.
3. That the breach was the proximate cause of the plaintiff's injuries, and
4. Damages (emotional, physical, or financial) occurred.

Standard of Care

The level of care that an ordinary, reasonable, and prudent professional with similar knowledge or skill would exercise in similar circumstances in a similar locale.

Statute of Limitations

The statute of limitations for personal injury typically lasts for two years after a person reaches majority (18 years old).

Release of Protected Health Information - HIPAA

CORE ELEMENTS

Identity of party authorizing disclosure

Identity of person(s) who provide disclosure

Identity of person(s) who receive disclosure

Description of Information for Disclosure

Purpose of the Disclosure of information

Expiration date or event

Signature of individual and date

* Note: Generally FERPA outweighs HIPAA when services are delivered in a school.

Release of Protected Health Information - HIPAA

STATEMENTS REQUIRED:

- Right to revoke the authorization
- Treatment not conditioned on signing
- Redisclosure of PHI

Release of Education Records - FERPA

- Specify the records that may be disclosed
- State the purpose of the disclosure
- Identify the party to whom disclosure made
- Signed and dated written consent (electronic as well)

Retention of Records - FERPA

- Maintain a record of request for access to and disclosure of personally identifiable information
  - Who requested it
  - “Legitimate educational interest” of requestor
- Maintain record with the education records of the student
- Doesn’t apply to parents, eligible students, school official, those with written consent from parent, those seeking directory information or those seeking or receiving via subpoena

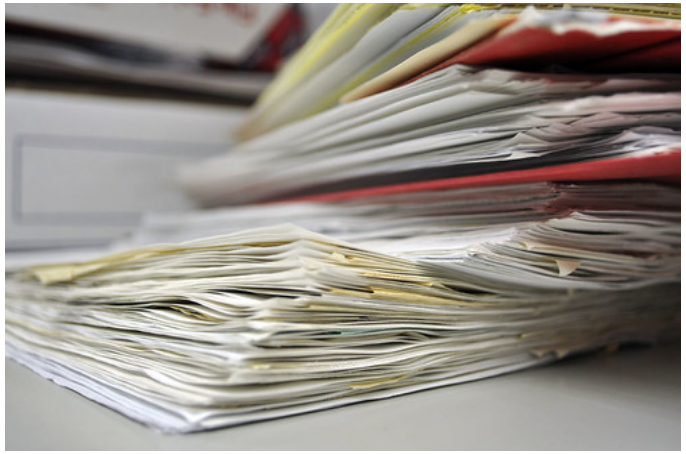
Destruction of Special Education Records

Destruction of information §300.624

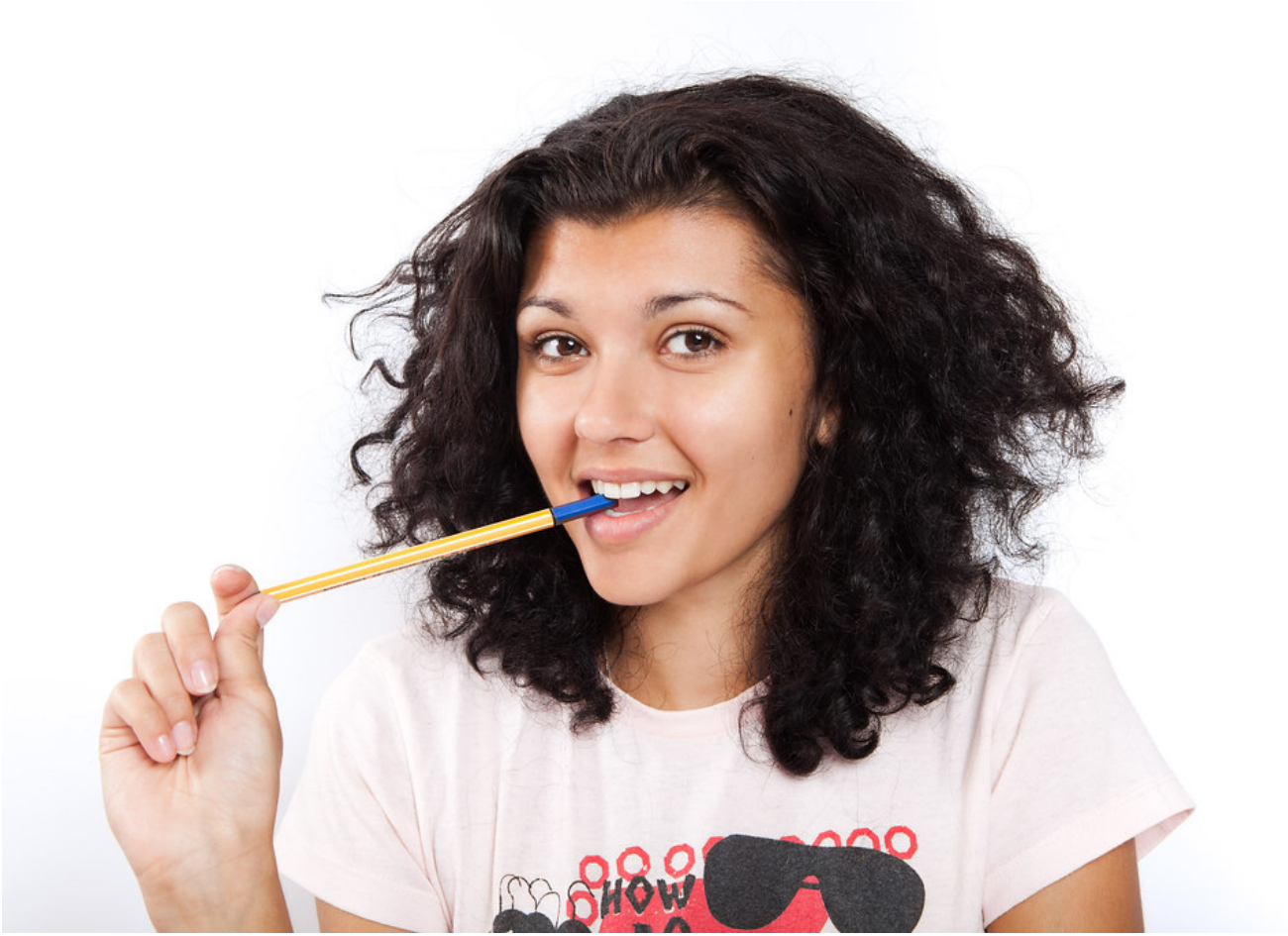
- (a) The public agency must inform parents when personally identifiable information collected, maintained, or used under this part is **no longer needed to provide educational services** to the child.
- (b) The information **must be destroyed at the request of the parents**. However, a permanent record of a student's name, address, and phone number, his or her grades, attendance record, classes attended, grade level completed, and years completed may be maintained without time limitation.

Presentation Summary

Student records should use electronic communication mediums carefully, keep private notes separate from official records, and destroy records only after careful consideration.



Questions?



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THANK YOU!

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