

Recordkeeping when Therapy is Provided at Domestic Violence Programs:

A Road Map to Developing Policies for Documentation & Protection of Records When Mental Health Providers are on Staff

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Domestic violence (DV) programs are now providing a more diverse array of advocacy and support services than ever before, including assistance with accessing mental health services. In some communities, DV programs have successfully worked to build collaborative relationships with local mental health providers. However, a nationwide shortage of affordable services has made this strategy impossible in other communities. Even where affordable mental health services are relatively available, these services may not be trauma-informed, culturally relevant, or designed to address complex trauma or meet the unique needs of survivors of interpersonal violence.

DV programs have sought to design policies and practices that will allow for mental health providers working at these programs to meet their professional obligations for proper documentation of therapy sessions with survivors, while also protecting these records from being subpoenaed by abusive partners.

For these reasons, some DV programs have sought funds to provide mental health services directly, including by hiring mental health providers on staff or engaging them as consultants to provide on-site therapy. These programs have hoped that their efforts would ensure that survivors who need mental health services are not impeded by long waitlists, logistical or financial obstacles, or providers who are not culturally competent or skilled at working with survivors of trauma. This strategy has also ensured that treatment services are provided within a DV advocacy framework.

At the same time, providing mental health services in this non-traditional setting has raised questions about how best to ensure that records of therapy sessions with survivors are afforded the utmost confidentiality protection permitted under the law. DV programs have sought to design policies and practices that will allow for mental health providers working at these programs to meet their professional obligations for proper documentation of therapy sessions with survivors, while also protecting these records from being subpoenaed by abusive partners.

This document is intended to be educational in nature.
Nothing in this document is intended as legal advice.

Getting Started – It’s Not “One Size Fits All”

The best strategy for properly documenting and protecting survivor mental health records will vary not only from state to state but also across agencies, depending on a number of factors. Some states have stronger laws protecting mental health records from subpoena than other states. Meanwhile, ethical standards related to documentation practices vary from profession to profession, while insurance companies and other healthcare payers may require varying details related to documentation before they will cover the cost of services.

For these reasons, no one-size-fits-all solution exists to the question of how mental health providers working at DV programs can meet their professional ethical obligations regarding recordkeeping while also acting to maximally safeguard survivor records.

This resource is intended as a “road map,” designed to assist DV coalitions and DV programs in identifying the relevant factors and sources of regulation that they must consider as they develop the policies and practices for maintaining and protecting mental health records that will best meet the needs of survivors served by their agency.

Protecting Documentation & Documenting Protectively: The Need for Multiple Strategies

The right to keep personal health and mental health data confidential is a value that is widely shared. In addition, individuals who have recently left an abusive partner may be engaged in ongoing custody cases or other legal proceedings. Abusers may seek to obtain their partner’s records to use against them in court, and may also be motivated by a desire simply to invade their partner’s privacy and humiliate them. DV programs that have hired mental health providers must therefore be prepared to strongly resist subpoenas for survivors’ mental health records. When state laws are protective and DV programs are able to effectively rely on these laws to quash inappropriate subpoenas, survivors’ mental health records will remain private.

At the same time, however, mental health providers must be mindful that there is *always some risk* that the documents they are creating will be subpoenaed. Furthermore, in some cases, documentation of the mental health provider’s interactions with the survivor and her children may be helpful to the survivor in court, for example, as evidence that the survivor is a caring and attentive parent. The first question, therefore, is not how to protect existing documents but how to document protectively in the first place. Practices for documentation should be informed by consideration of the minimal level of documentation that may be required, as well as best practices for what and how to document when working with domestic violence survivors.

Question 1: What Minimal Level of Documentation is Required?

A mental health provider's professional code of ethics may provide aspirational or mandatory guidelines related to standards of documentation. In addition, if the agency is billing for services, insurance companies may have certain requirements related to documentation. Finally, regardless of whether an agency is billing for services, the agency's policies regarding minimal documentation may also be impacted by malpractice concerns.

Codes of Ethics

Many professional organizations have codes of ethics regarding recordkeeping and client confidentiality. Keep in mind, however, that many ethical codes contain both aspirational guidelines, which are non-binding and/or may intentionally be written to allow room for interpretation and professional judgment, as well as rules that the professional must follow, or else risk sanctions. For example, the American Psychological Association has a section regarding general principles as well as a section of ethical standards. Here, only the ethical standards are enforceable against members.

The American Counseling Association requires counselors to keep records "necessary for rendering professional services." Similarly, the National Association of Social Workers provides that members should create "sufficient...documentation...to ensure continuity of services," while avoiding documentation of irrelevant and potentially harmful information: "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."

The American Psychiatric Association, which publishes annotations on the general American Medical Association's Code of Ethics, does not specifically address minimal documentation requirements but does consider the conflict between obeying a court order and acting in the patient's best interest.

The following organizations have professional ethical codes:

[American Psychiatric Association](#)
[American Psychological Association](#)
[American Association for Marriage and Family Therapy](#)
[American Counseling Association Code of Ethics](#)
[National Association of Social Workers](#)

For a more complete list of ethical codes, visit <http://kspope.com/ethcodes/>

Insurance Companies

DV agencies that provide mental health services will need to decide whether to bill for services. Private insurance, as well as the state's Medicaid/Medicare authorities will have requirements regarding documentation needed for reimbursement. What exactly is required, however, may vary.

DV programs will need to review the requirements of individual insurance providers to determine what documentation is required for reimbursement. For example, many insurance companies and state Medicaid authorities will only pay for mental health treatment that is "medically necessary" and it will be up to the mental health provider to show that treatment is necessary based on a person's symptoms, diagnoses, and general functioning. If medical necessity is not required, there may still be reporting requirements, such as the date and duration of services, symptoms, diagnoses, treatment care plans, progress reports, and information about treatments and responses to treatment.

Additionally, documentation in the medical record should support any billing codes used to bill for services. This ensures that the agency will be able to respond to requests for further documentation, as well as to appropriately respond in the unlikely event that wrongdoing is alleged. This supporting documentation should be no more than is necessary based on the payer's requirements and should not include any language that could fall under "psychotherapy notes" as defined by the HIPAA regulations, because these notes are subjected to a higher standard of protection.

What are psychotherapy notes?

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. 48 CFR 164.501.

Ultimately, billing for services may be worthwhile to some agencies as it can help cover the financial burden of providing mental health services in house. On the other hand, some agencies may decide that billing for services is not worth the logistical burden or the confidentiality risk for survivors. Each agency must balance its own needs and capacity.

Malpractice

Recordkeeping can also provide some protection against malpractice claims, inasmuch as records can provide documentation that professionals are not responsible for alleged wrongdoing. Some malpractice experts may recommend fairly extensive documentation practices for this reason. On the other hand, one insurance company's psychiatric and professional liability risk management group advises psychiatrists to "document objectively and only use the facts and clinical opinions that are relevant to the diagnosis and treatment of the patient." The company further advises that information about sexuality, criminal history, interpersonal conflict, and names of third parties "may not need to be included, unless relevant to patient treatment."^{*}

DV agencies should be cognizant that recordkeeping practices can impact their ability to respond to malpractice suits and should seek legal advice as appropriate.

Question 2: What are the Best Practices for Documentation?

*In 2007, the Domestic Violence & Mental Health Policy Initiative (DVMHPI) in collaboration with A Growing Place Empowerment Organization, Life Span, Thresholds, and the Illinois Department of Human Services, Division of Mental Health published Access to Advocacy: Serving Women with Psychiatric Disabilities in Domestic Violence Settings — Participant Guide Slides. The section that follows is a summary of Module Four, written by **Denise Wolf Markham, JD**, Director of Life Span for Legal Services and Advocacy, a Chicago-based legal services agency serving survivors of domestic violence.[†]*

Even in states with protective confidentiality and privilege laws, there is always a possibility that records can be successfully subpoenaed. In these cases, documentation can be used against survivors in court. An abuser may attempt to show that a survivor with "mental health issues" is not credible, that the abuser's actions were justified, that the survivor is not capable of parenting, or that the abuse never occurred but rather is a symptom of mental illness.

On the other hand, there may be many cases in which documentation in a survivor's mental health record may actually be helpful in the survivor's legal case—especially if the survivor has an attorney who is knowledgeable about how to properly use these records in the case.

^{*} Allied World Assurance Company: American Professional Agency, Medical Records: Protection for the Psychiatrist and the Patient (2016), available at http://www.americanprofessional.com/wp-content/uploads/AACAP_MedicalRecordsProtection.pdf.

[†] The full text of Access to Advocacy can be located here: <http://www.nationalcenterdvtraumamh.org/publications-products/access-to-advocacy-serving-women-with-psychiatric-disabilities-in-domestic-violence-settings-participant-guide/>

In these cases, documentation can be used to counter claims made by the abuser by documenting the abuse and showing that the survivor's story is consistent. Documentation can also provide evidence that the survivor is a caring and capable parent, or be used to show that the survivor is complying with treatment recommendations. For example, if the mental health provider observes the survivor parenting, the provider can document if these interactions are supportive and loving, as well as if the children are clean, dressed well, and if they respond warmly to the survivor. Documentation should always include any observations of physical abuse, such as bruising, or actions that reflect the impact of the abuse, such as crying when describing what happened. If the survivor does have visible bruises, ask permission to take a photo add to the survivor's records.

Finally, avoid documenting potentially stigmatizing or harmful information, such as that the survivor has engaged in sex work or has used illegal drugs. Documentation of this kind of information should be done only when truly necessary to meet ethical and/or legal requirements.

Even if a survivor is not planning to admit records in their legal case, best practice is to always document sessions with these guidelines in mind.

Question 3: What Confidentiality Protections Are Provided by Federal Law?

Most DV programs receive funding under the Family Violence Prevention and Services Act (FVPSA) and many receive funding under the Violence Against Women Act (VAWA). The federal regulations associated with these statutes contain parallel confidentiality requirements that apply to funding recipients. These regulations contain strong protections prohibiting the disclosure of information about the individuals who seek services through the programs receiving these funds. The regulations prohibit the release of any information about program participants without their written consent, unless release is "compelled by statutory or court mandate."[‡]

FVPSA and VAWA regulations both prohibit funding recipients from releasing any information about program participants without their written consent, unless release is "compelled by statutory or court mandate."

Additionally, it is possible that DV programs that provide mental health services may also be bound by the Health Insurance Portability & Accountability Act (HIPAA). HIPAA protects

[‡] This language comes from the FVPSA regulation (45 CFR 1370), which was updated in November 2016 and is available at <https://www.federalregister.gov/documents/2016/11/02/2016-26063/family-violence-prevention-and-services-programs>.

medical and other health information, providing protocols under which this information can be shared with patient consent and in the absent of patient consent.

For more information about federal laws, visit the Technology & Confidentiality Resources Toolkit (link below).

TECHNOLOGY & CONFIDENTIALITY RESOURCES TOOLKIT

This web-based toolkit is a collaboration between the National Network to End Domestic Violence (NNEDV) Safety Net Project, the Confidentiality Institute, and the Office on Violence Against Women. It provides invaluable information for DV programs on confidentiality rules and laws, as well as best practices for recordkeeping. It also includes sample privacy policies, waivers, and release templates.

<http://second.worldshelterconference.org/>

Question 4: What Privileges are Recognized by State Law?

An evidentiary privilege is a legal protection that covers private communications made within certain special relationships. Commonly recognized privileges are attorney-client privilege, psychotherapist-patient privilege, and clergy-penitent privilege. Some states recognize a victim advocate privilege and others do not. These privileges belong to (and can only be waived by) the client/survivor. The provider cannot decide to waive them. The provider or victim advocate must do everything in their power to protect the privilege, including challenging a subpoena that seeks the disclosure of privileged information.

For example, Illinois law makes privileged the confidential communication between domestic violence advocates or counselors and survivors. In addition to communications, the privilege also includes all records made by the advocate, counselor, or domestic violence program for the purpose of providing information, counseling, or advocacy to the victim. The only exceptions to privilege are if disclosure is made “(1) in accordance with the provisions of the Abused and Neglected Child Reporting Act or (2) in cases where failure to disclose is likely to result in an imminent risk of serious bodily harm or death of the victim or another person.”[§]

State laws vary in the extent to which they recognize therapist-client privilege and advocate-victim privilege. In some states, communication within one of these relationships may be more protected than the other. Other states, like Illinois, may recognize privilege

[§] 750 Ill. Comp. Stat. 60/227(b).

for all records created by the program. DV programs providing mental health services should investigate their state laws to see what privileges are recognized in their states.

Additionally, a critical rule for maintaining a privileged communication is that other parties cannot be present unless they are necessary for the communication to take place. For example, an interpreter may be present and the privilege will remain intact. However, if other parties are present, particularly family members, a court may find that the privilege was waived. DV programs should check their state laws and ensure that their policies and practices do not result in the unintentional waiver of privilege.

Checking Your State's Privilege Laws

Summary of U.S. State Laws Related to Advocate Confidentiality (2014)

By Alicia Aiken and Julie Field, Confidentiality Institute

http://www.americanbar.org/content/dam/aba/uncategorized/cdsv-related/Advocate_Confidentiality_Chart_2_2014.authcheckdam.pdf

State Confidentiality Statutes (a comparison chart of privileges offered in all 50 states)

By Legal Momentum

<http://www.lsc.gov/sites/default/files/LSC/pdfs/8.%20%20Appendix%20VI%20%20Handout%2030%20State%20Confidentiality%20Chart%207-20.pdf>

Note that these resources are useful starting places, but individuals should investigate to see if the statutes listed have been changed or modified, and if other statutes have been passed.

Question 5: What if I am Subpoenaed?

Subpoenas are used to obtain documents and/or testimony for a legal case. Every DV program should have a protocol for how to respond to subpoenas, and every staff member should be trained in how to respond if they are served, meaning that they are the person who is handed the subpoena documents. This should include IMMEDIATELY notifying the staff member who is designated to respond to the subpoena. The DV program should then contact their attorney if they have one. Some states have developed networks of pro bono attorneys who are available specifically to assist DV programs that are served with subpoenas. If possible and appropriate, the DV program should also notify the survivor. The survivor may have their own attorney who can assist in responding to the subpoena.

Not all subpoenas are the same. A subpoena issued by a judge acts a court order, but a subpoena issued by an attorney or clerk of the court does not hold the same weight. An attorney can request anything in a subpoena, but as discussed above, federal and state laws

may limit what a judge will ultimately require be turned over if the subpoena is challenged. In either event, a subpoena that requests privileged information can and should be challenged. This may involve filing a motion to quash the subpoena. For example, a motion to quash can argue that the information requested is privileged, or that it places an undue burden on the recipient.

Finally, in the event that a court ultimately requires information to be disclosed, always look closely at what is being requested and never turn over more information than is being requested.

Resources on How to Respond to Subpoenas

Every DV program should have a protocol for how to respond to subpoenas. The following resources can assist programs in developing their plan.

Protecting Privacy to Enhance Safety Pro Bono Project

The ABA and the Confidentiality Institute have partnered to develop this project, which is designed to create a corps of attorneys nationwide who are knowledgeable in the area of advocate confidentiality and can provide pro bono assistance to programs to respond to subpoenas when they come in. This website contains resources, webinars, and templates. http://www.americanbar.org/groups/domestic_violence/subpoena_defense_project.html

How to Respond to Subpoena (2016)

NNEDV Safety Net Project, Confidentiality Institute, and ABA Pro Bono Project
https://static1.squarespace.com/static/51dc541ce4b03ebab8c5c88c/t/57eea784e4fcb5ffe664198e/1475258246173/NNEDV_CI_How+to+Respond+to+a+Subpoena_2016.pdf

Subpoena Response Toolkit: A Guide for Mental Health Service Providers on How to Respond to Subpoenas and Other Demands for Client Information or Records (2011)

National Center on Domestic Violence, Trauma & Mental Health
<http://www.nationalcenterdvtraumamh.org/publications-products/subpoena-response-tool-for-mental-health-providers/>

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