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Documentation in Social Work: Evolving Ethical and Risk-Management Standards

Frederic G. Reamer
Rhode Island College, freamer@ric.edu

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Social workers' understanding of the relevance of documentation has evolved over time. During the profession's earliest years, social workers viewed documentation primarily as a mechanism to facilitate theory building, research, and teaching. This was followed by social workers' development of detailed and sophisticated documentation standards for clinical and other direct practice settings. Most recently, social workers have begun to appreciate the relevance of documentation for risk-management purposes, particularly as a tool to protect clients and to protect practitioners in the event of an ethics complaint or lawsuit. This article updates the profession's literature on documentation by summarizing current ethical and legal standards. Implications for social work practice, supervision, management, and administration are addressed.

KEY WORDS: *case recording; documentation; ethics; records; risk management*

Throughout social work's history, practitioners have recognized and appreciated the usefulness of recording their encounters with clients (Aptekar, 1960; Frings, 1957; Kagle, 1984, 1987, 1991, 1995a; Little, 1949; Timms, 1972; Urbanowski, 1974; Wilson, 1980). Case documentation not only supports the delivery of services to individuals, families, couples, and small groups, but it increasingly has new applications in keeping with the changing environment in which social workers operate. Traditionally, documentation helped practitioners coordinate and evaluate service needs and delivery. More social workers, however, realize the significance of documentation as a liability shield and risk-management tool. This warrants a fresh look at documentation so that practitioners, supervisors, and agencies can apprise themselves of proper documentation techniques, related ethical standards, and the potential pitfalls social workers may face as they shift their practices.

During social work's earliest years, in the early 20th century, discussions about documentation focused almost exclusively on theory building, research, and teaching (Eliot, 1928; Hamilton, 1936, 1946; Richmond, 1925; Sackheim, 1949; Sheffield, 1920; Sytz, 1949). By the 1920s and 1930s, social work's literature emphasized the importance of record keeping when "personality influences, psychological goals, and psychiatric casework were involved" (Pinkus, 1977, p. 1162). By 1940, professional standards had evolved for three distinct types of case records: (1) chronological reports of services provided, (2) summary recordings of practitioners' relationships with clients, and (3) process recordings that provide moment-by-moment details of clients' behavior and interactions between practitioners and clients (Burgess, 1928). Over time social workers refined their recording practices with respect to assessing clients' circumstances, statuses, and needs; documenting more subjective information about clients' circumstances (information provided by the client, family, and significant others); recording objective information based on tests or other independent sources, the social worker's assessment, and plans; and completing standardized forms that summarize client information using short answers or checklists (Kagle, 1987, 1995b).

Until fairly recently, discussions of case recording and documentation focused almost entirely on clinical relevance. That is, the field primarily saw documentation's function as a diagnostic, assessment, planning, and intervention instrument. In the

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mid-1990s, however, a burgeoning group of social workers began to recognize the relevance of documentation for risk-management purposes. The shift was largely a result of growing awareness that case records were applicable in utilization review and managed care, as well as in defense against ethics complaints and lawsuits alleging unethical conduct and professional negligence (Houston-Vega, Nuehring, & Daguio, 1997; Kagle, 1995b; Reamer, 2003). In addition, dramatic technological innovations—especially in the form of pervasive computerized records and the potential for problems concerning privacy and unauthorized access—fueled risk-management concerns. Together, these changes have resulted in a growing appreciation of how careful documentation and record keeping protect practitioners against allegations of ethical misconduct and professional negligence, guard clients' privacy, and facilitate the delivery of high-quality services.

In recent years, documentation-related standards have evolved to reflect these newer risk management functions. Most contemporary social workers, however, graduated before the current standards were developed and incorporated into social work curricula. In fact, the last major publication on documentation written specifically for social workers appeared in 1995—well before the emergence of several key current standards (Kagle, 1995b). Since then there have been noteworthy expansions of ethical standards on social work documentation (Reamer, 1998, 2003) and scholarly literature on the broader subject of documentation (Berner, 1998; Luepker & Norton, 2002).

CONTEMPORARY FUNCTIONS OF DOCUMENTATION

Discussions of social work documentation are no longer limited to clinicians who need to record their interactions with clients to facilitate the delivery of services. The profession has come to recognize the usefulness of documentation for risk management purposes in supervision, management, and administration. Documentation in social work—whether it concerns clinical, supervisory, management, or administrative duties—now serves six primary functions: (1) assessment and planning; (2) service delivery; (3) continuity and coordination of services; (4) supervision; (5) service evaluation; and (6) accountability to clients, insurers, agencies, other providers, courts, and utilization review bodies (Kagle, 1995b; Luepker & Norton, 2002; Reamer, 2003).

Assessment and Planning

In clinical contexts, clear and comprehensive documentation of all case-related facts and circumstances is essential. Careful and thoughtful information collection ensures that social workers have an adequate foundation for their clinical reasoning and intervention plans. In addition, the data provide a reliable source of measuring performance and outcomes. Incomplete records may lead to inadequate planning and intervention, critical judgment errors, and poor outcomes for clients.

Service Delivery

Comprehensive records are necessary for competent delivery of clinical, community-based, and agency-based services and interventions. Thorough documentation provides a solid foundation for practitioners' efforts to design and deliver high-quality services, whether they involve clinical intervention, efforts to organize community residents to address neighborhood problems, supervision, or agency administrators' management and evaluation of personnel and programs.

Continuity and Coordination of Services

Similarly, documentation facilitates professional and interdisciplinary collaboration and coordination of services. For example, social workers employed in hospital, school, and correctional settings often need to share their observations and coordinate services with professionals in other disciplines, such as doctors, nurses, counselors, teachers, and administrators. In clinical settings, documentation ensures that staff members have up-to-date details concerning clients' needs. Administrative records facilitate coordination among supervisors, managers, and administrators in programs and agencies.

Supervision

Under the legal doctrines of vicarious liability and *respondeat superior* ("let the master respond"), supervisors, as well as administrators and agencies, can be held liable for the errors and omissions of their staff if there is evidence of flawed supervision (Madden, 2003; Reamer, 2003, 2004). Thus, it behooves social work supervisors to carefully document the supervision they provide (NASW, 1994).

Service Evaluation

In addition to facilitating clinical evaluation in individual cases (so-called single-case or $N = 1$ designs), records also provide essential data for broader program evaluations (Fitzpatrick & Sanders, 2003; Patton, 2002; Royse, Thyer, Padgett, & Logan, 2000). Measured outcomes and program effectiveness are central to social work. At their core lie data and information recorded throughout the case management process. Social workers must strive to continually strengthen their record-keeping practices to maintain the integrity of their programs.

Accountability

Client requests, insurance contracts, interagency collaboration, litigation, licensing board and ethics committee oversight, and utilization review bodies periodically require social workers to include fine-grained details about the services they provide, the meetings they attend, the supervision they offer, and the consultation they obtain. These new demands clearly illustrate the fit of documentation for accountability purposes.

EVOLUTION OF DOCUMENTATION STANDARDS

When social work's pioneers began writing about case recording in the early 20th century, they could not have imagined the remarkable expansion of documentation functions and requirements that would emerge during the next century. Today's social workers are held to vastly different ethical and legal standards that have serious implications for clinical and community practice, supervision, management, and administration.

Ethical Standards

Social work's earliest national ethics standards made no mention of documentation. Neither the first National Association of Social Workers (NASW) *Code of Ethics*, adopted in 1960, nor the revised *Code of Ethics*, adopted in 1979, included guidelines concerning documentation. The current *Code of Ethics*, adopted in 1996 (and revised in 1999), however, includes the first explicit documentation standards (Reamer, 1998). These ambitious additions to the *Code* reflect increased cognizance of the ethical implications of competent documentation during the mid-1990s.

The primary focus of the earliest standards centered on social workers' ethical duty to document the services they provide, clients' right to view their records, and social workers' duty to protect clients' records from unauthorized access or use (Reamer, 1998). The 1996 NASW *Code of Ethics* formally promulgated social workers' ethical duty to accurately document the services they provide and protect private information contained in records, thus establishing national standards enforced by NASW committees on inquiry and by state licensing boards that choose to adopt NASW *Code of Ethics* guidelines. Specifically, the measures state:

> 3.04 Client Records
>
> (a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.
>
> (b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
>
> (c) 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. (NASW, 1996, p. 20)

Two additional standards in the 1996 NASW *Code of Ethics* formally established clients' right to access their own records and social workers' duty to protect the confidentiality of other parties referred to in the record. Specifically:

> 1.08 Access to Records
>
> (a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records. (p. 12)

Finally, two more standards set forth practitioners' ethical duty to store records in a way that protects clients' confidentiality and makes the records available following the termination of services.

1.07 Privacy and Confidentiality

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access. (pp. 10–11)

3.04 Client Records

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts. (p. 20)

Risk-Management Standards

In addition to spreading new ethics standards related to documentation, social workers have also recently developed elaborate risk-management standards designed to enhance the delivery of services to clients and protect practitioners in case they have to defend themselves against ethics complaints (filed with state licensing boards or NASW) or lawsuits that allege professional negligence (Barker & Branson, 2000; Madden, 2003). The following section provides a summary of these guidelines, based on extant literature, prominent court decisions, and my experience as chair of an NASW chapter committee on inquiry and as an "expert witness" (Gifis, 1991) in many court cases throughout the United States in which social workers have been plaintiffs or defendants.

RISK-MANAGEMENT GUIDELINES

Risk-management guidelines related to documentation and case recording can be placed into four conceptually distinct categories: (1) the content of documentation, (2) language and terminology, (3) credibility, and (4) access to records and documents.

Content of Documentation

Too much content, too little content, or the wrong content can harm clients and expose practitioners to considerable risk of liability. The days when social workers could proclaim, "I just don't keep detailed notes" are long gone. As Berner (1998), a lawyer and social worker, observed with respect to documentation in clinical settings:

> Because the practice of clinical record-keeping is of such long standing, and because courts in particular understand that the reason for clinical documentation is, in fact, not for the convenience of attorneys and judges, but to further the goal of good patient care, "everyone" expects that clinicians will keep records. "Everyone" means your patients, your professional society's ethics board, your professional discipline's licensing board, the newspapers, the general public, and perhaps most relevant for us ... the courts. Courts know what everyone else knows, and courts expect clinicians to keep records documenting their work. (pp. 60-61)

Or, as many attorneys assert, "If you didn't write it down, it didn't happen." To ensure appropriate content in documentation, social workers should consider several issues. A primary function of documentation is to serve and protect all parties. The content, however, must tread a careful line, striking a balance between too much and too little information. In a crisis situation, social workers need to observe some precautions when recording case information. In addition, practitioners must understand the double-edged sword of keeping personal notes during case management. Furthermore, there are specific guidelines for documenting services to families and couples, and the extent to which individual members may be privy to that information. Finally, although in some instances it may appear prudent to document staffing issues and professional disagreements regarding service delivery, doing so may be akin to airing dirty laundry—and may make an agency ripe for litigation.

Serve and Protect. Practitioners' first rule of thumb when documenting cases should be to include sufficient detail to facilitate the delivery of services and protect themselves in the event of an ethics complaint or lawsuit. In clinical settings, such details involve social histories, assessments, and treatment plans; informed consent procedures; contacts with

clients (type, date, and time); contacts with third parties; consultation with other professionals; decisions made and services provided; critical incidents; instructions, recommendations, advice, and referrals to specialists; failed and cancelled appointments; previous or current psychological, psychiatric, and medical evaluations; information concerning fees, charges, and payments; termination of services; final assessment; and other relevant documents (Moline, Williams, & Austin, 1998; Reamer, 2001).

Social work supervisors should document the date, time, and content of supervision sessions, including specific recommendations, critical incidents, and consultations. Social work managers and administrators should document key discussions, consultations, and meetings that address ethical and legal issues. For example, they should note the steps taken to determine whether to disclose confidential information without a client's consent to protect a third party from harm, address an employee's impairment or unethical conduct, or develop conflict-of-interest guidelines for agency personnel (Barsky & Gould, 2002; Luepker & Norton, 2002). David Gould (1998), a veteran malpractice attorney who has defended several mental health practitioners wrote:

> These types of cases, like almost all medical negligence cases, are won or lost by what is contained, or not contained, in the medical record. It has been my experience that mental health notes, particularly in the outpatient setting, are, more often than not, deficient. . . . Inadequate notes leave the clinician at the mercy of a plaintiff's attorney, especially when he is asked years later to recall an event that is poorly documented, if at all. (p. 345)

Strike a Balance. Documenting too much or too little can be perilous (Berner, 1998). For example, in clinical settings too little detail about a client's suicidal ideation may compromise the quality of services provided by an on-call colleague who reviews incomplete or vague entries in the client's chart. Furthermore, social workers who do not include sufficient detail concerning the steps they took to address a client's crisis are likely to have difficulty defending their actions in the event of an ethics complaint or negligence lawsuit (Bergstresser, 1998).

Too much detail—a client's fantasies, for instance—could be used against the client if that client's spouse subpoenas the record as part of a child custody dispute. Admittedly, distinguishing between too much and too little detail can be difficult. It requires experience and reasoned decision-making. Social workers should strive for a reasonable balance considering what information is clinically essential to properly assess clients' needs; plan, coordinate, deliver, supervise, and evaluate services; and be accountable to clients, insurers, agencies, other providers, courts, and utilization review bodies.

Avoid Overdocumentation in a Crisis. Social workers also need to strive for balance during crises, avoiding the temptation to "over-document." Including excessive detail in a case record in the context of a crisis can serve as a "red flag" when records are reviewed during an ethics hearing or litigation (Bergstresser, 1998; Simon, 1998). A social worker's claim that she or he handled the matter in a manner that is consistent with prevailing standards in the profession may be challenged in the face of inordinate detail in the case record. Such detail may in fact suggest that the case was handled in an extraordinary or unusual way. As Berner (1998) asserted, it is far more important in a clinical crisis to "write smarter, not longer. . . . *Writing smarter* means being succinct" (p. 54).

Use Caution with Personal Notes. Clinical social workers, supervisors, managers, and administrators sometimes maintain separate personal notes to keep track of details that do not belong in an official agency record. Social workers sometimes assume—mistakenly—that such personal notes will always be treated as confidential and that adversarial parties cannot gain access to them, for example, in a malpractice lawsuit. In fact, in most court jurisdictions, lawyers can subpoena social workers' personal notes during legal proceedings (Polowy & Gorenberg, 1997). Thus, social workers who maintain personal notes assume some risk. Information in personal notes could be used against one's client. For example, information contained in the notes may become central during divorce, termination of parental rights, or child custody proceedings. Personal notes can also be used against the social work supervisor, manager, or administrator who documents potentially embarrassing details concerning inter-staff relationships. Social workers who maintain personal notes should word entries without an expectation of privacy and with the assumption that someday the notes may be reviewed by

third parties whose interests may be adversarial (Moline et al., 1998).

Be Cautious in Documentation of Services for Families and Couples. Clinical social workers who counsel families and couples are often in an untenable position: If they maintain a single record for the family and couple, they risk exposing confidential information in the event the record is subpoenaed. Maintaining separate records for all parties, on the other hand, is cumbersome and inconsistent with social workers' belief that the family or couple as a whole is the client. According to Barker and Branson (2000):

> There are advantages and disadvantages to whichever choice this worker, or any worker, makes. The only virtue in having separate files—but it is a significant one—is in the event that members of the client-group have major disputes. When their disputes lead to legal action, one client or another may seek the worker's files. An individual may be able legally to have access to his or her own records, but what about when the information is intertwined with that of another person, especially another person who is now an opponent in a lawsuit? If the files are written separately, then every person can claim access only to their own files, and the worker's position is much less uncomfortable. (pp. 154–155)

Some social workers compromise by maintaining separate records for sensitive information that must be protected and joint files for more routine assessments and summaries of services provided. For example, a social worker who provides an individual counseling session to one member of a couple, as a supplement to counseling the couple, can create a separate file for that client in which private issues, such as a report of struggles with sexual orientation, family violence, or substance abuse, are recorded. In the couple's joint file, the social worker would record the fact that they sought marital counseling to address "relationship issues." Maintaining separate records in these circumstances may help the social worker protect each individual client in the event that a dispute arises—a child custody dispute or divorce, for example (Barsky & Gould, 2002; Moline et al., 1998; Reamer, 1998). In such circumstances social workers should consult standards in the NASW *Code of Ethics* concerning conflicts of interest that can arise when they "provide services to two or more people who have a relationship with each other" (Standard 1.06[d]). It is the social worker's duty to explain at the outset his or her role during the case and to anticipate and minimize potential conflicts of interest.

Do Not Air Agency Dirty Laundry. Details concerning understaffed programs or personal opinions about the competence of a colleague do not belong in a client's record. Documentation of personnel and staffing problems should appear in administrative files. Including such detail in clients' records may expose agencies to considerable risk in the event of a negligence lawsuit (Simon, 1998).

Furthermore, line social workers, supervisors, managers, and administrators who become involved in disputes among staff members —a disagreement about an agency policy or administrative order, for example—should not include documentation about the dispute in clients' records. When there is reason to create a paper trail, relevant opinions, decisions, and actions can be documented in administrative memoranda or logs. Put simply, evidence of "jousting" among staff should not appear in clients' records (Berner, 1998; Simon).

Language and Terminology

Wording in documentation is just as important as the substance of the content. Loose and casual language and terminology can be catastrophic to the social worker, the supervisor, and the agency. Social workers must choose their words carefully, taking care to be clear, to fully support conclusions drawn, to avoid defamatory language, and to write knowing there is always an audience.

Gaining Clarity. Practitioners should use clear, specific, unambiguous, and precise wording. Lack of clarity, specificity, and precision provides considerable opportunity for adversarial parties to raise doubts about social workers' claims, observations, and interpretations. In addition, these shortcomings in a report may confuse colleagues who are depending on the notes to provide follow-up services to clients (Reamer, 2003; Simon, 1998). Conversely, clear, specific, unambiguous, and precise wording enhances the delivery of services and strengthens social workers' ability to explain and defend prior decisions and actions.

In addition to using precise wording, social workers should avoid the use of professional jargon, slang, or abbreviations that may be misunderstood. For

example, the abbreviation "DD" could mean dual diagnosis or developmental disability. The abbreviation "BPD" could mean bipolar disorder or borderline personality disorder. "SA" could mean substance abuse or sexual assault. Such ambiguity could prove disastrous if the abbreviations are misinterpreted by a colleague or debated in an ethics hearing, licensing board inquiry, or litigation.

Drawing Conclusions. It is very risky to document conclusions with terms or phrases such as "the client was confused" or "the unit social worker behaved aggressively toward the client" without including supporting details. Today's practitioner, therefore, needs to always include explanatory details that support a conclusion or assertion. Summary statements about the mental health status or behavior of a client, employee, or colleague should always be supported with sufficient details. Terms such as "hostile," "under the influence," or "incompetent" should always be reinforced and followed by the phrase "as evidenced by ..." with appropriate details included (Bergstresser, 1998; Berner, 1998).

Avoiding Defamatory Language. Practitioners should also take steps to avoid using language that might constitute libel or slander, the two forms of defamation of character (Moline et al., 1998; Reamer, 1998). Libel (the written form of defamation) and slander (the oral form of defamation) occur when social workers write or say something about a client, colleague, or third party that is not true, the social worker knew to be untrue or should have known was untrue, and harmed the individual who was the subject of the written or oral communication. Examples include untrue statements alleging mental illness, substance abuse, incompetence, or inappropriate behavior.

Writing for an Audience. Social workers should expect documents and records to be reviewed by managed care authorities, utilization review personnel, and third-party payers. Poorly worded and inadequate documentation may affect the likelihood that payment will be authorized for services to clients. Also, social workers should protect clients' privacy when they share records with such outside parties (see NASW *Code of Ethics*, standard 1.07[h]).

Credibility

When disputes arise concerning the appropriateness of social workers' actions—whether they conducted adequate assessments of clients, maintained proper boundaries, terminated services appropriately, obtained needed consultation, or provided proper supervision, for example—case records and administrative files provide essential evidence. Without thorough documentation, social workers may have difficulty defending their actions. Thoroughness, however, is not sufficient. Even thorough documentation needs to be credible, and the credibility of social workers' documentation can be enhanced or compromised in several ways. Time is of the essence when documenting cases, but practitioners must take care not to jump the gun and record events that are only anticipated. Likewise, elocution in documentation must always be professional. Finally, when a mistake is made, a credible social worker will be forthright and honest.

Documenting in a Timely Fashion. Few social workers relish the task of documentation, whether for clinical, supervisory, management, or administrative purposes. Documentation takes time and often looms as an onerous task—a necessary evil associated with professional life. As a result, social workers sometimes procrastinate and put off documenting their decisions and actions. Delayed documentation can compromise the credibility of social workers' claims about what is reflected in the notes (Berner, 1998; Moline et al., 1998; Simon, 1998). Adversarial parties, especially opposing legal counsel, can use evidence of delayed documentation to challenge the credibility of social workers' testimony. According to Barsky and Gould (2002):

> The timing of note taking can have great legal significance. Ideally, notes should be made contemporaneously with the events being recorded (i.e., during a session with a client, immediately following, or within 24 hours). Evidentiary rules assume that information recorded contemporaneously with the events is more likely to be accurate. Behavioral science research supports the fact that notes contemporaneously taken are more accurate than those recorded at a later time, even if it is later the same day. (p. 135)

Avoiding Prognostic Documentation. In an effort to save time and expedite documentation, social workers occasionally record notes in advance of an intervention or event. Sometimes, however, the planned interventions or events do not occur or

unfold differently than expected. The prematurely recorded notes would therefore not accurately reflect what happened and thus would undermine the social worker's credibility (Barsky & Gould, 2002; Berner, 1998).

Striving for Professional Elocution. Social workers do not always pay close attention to the legibility or grammatical correctness of their documentation. Colleagues may have difficulty understanding, or may misinterpret, illegible entries and may miss important cues that are essential for proper intervention, supervision, management, or administration. It is imperative, therefore, that when recording case information, social workers print or write entries legibly and use proper grammar. Copies of social workers' documentation typically become tangible evidence and exhibits during ethics hearings, licensing board inquiries, and courtroom proceedings. Photocopies and overhead transparencies may be displayed to peer-review or regulatory bodies, lawyers, expert witnesses, judges, and jurors. Illegible entries and a pattern of grammatical and spelling errors are a professional embarrassment to the practitioner and the agency represented. Such inattention to detail severely weakens credibility (Barsky & Gould, 2002; Moline et al., 1998; Simon, 1998).

Acknowledging Errors. To err is human, and every social worker is capable of inadvertently inserting incorrect facts into and omitting important facts from case documentation. Ethics committee members, licensing boards, lawyers, and judges recognize that any professional can make occasional errors.

To avoid undermining their credibility, social workers should never attempt to "cover up" or camouflage their errors (Barsky & Gould, 2002; Reamer, 2003). Such efforts can backfire. For example, opposing lawyers can access documents before social workers attempt to conceal the errors. Social workers who alter records in anticipation of legal proceedings, or after legal proceedings have been initiated, therefore, assume great risk and public humiliation if the inconsistencies are brought to light. As Barsky and Gould (2002) observed, "if a clinician is aware of an impending legal process or has been subpoenaed, doctoring or destroying documents can result in such charges as contempt of court or obstruction of justice, malpractice suits, and professional disciplinary actions" (p. 145). Instead, social workers should always acknowledge their errors, making clear that the new entry occurred after the error was discovered. In clinical settings, practitioners should enter a new note that acknowledges and corrects the error or draw a thin line through the error and insert the correction, along with the social worker's initials, the date, and the word "error." Clyde Bergstresser (1998), a seasoned malpractice attorney, emphasized:

> Do not change or lose your records. Do not make "additions" or "corrections" to clarify what you meant. You would be amazed at how many people cannot resist the temptation to make sure that in hindsight the records say what was meant. When you get caught, your credibility will be destroyed, and it is very likely you will be caught. Copies of "lost" records have a habit of cropping up when you least expect it. Document experts are now very sophisticated in their ability to determine from writing patterns whether an entry was made all in one sitting, even from a copy. (p. 342)

Access to Records and Documents

Social workers generally assume that case records and documents will remain confidential. In reality, there is no such thing as a truly confidential case record. An extraordinarily wide array of laws, regulations, contracts, and court rules require or permit disclosure of otherwise confidential documents.

Furthermore, social workers need to be cognizant of security risks associated with the widespread use of computers to store confidential records and documents. Thus, social workers should be very familiar with the various circumstances under which records and documents may be disclosed. Practitioners need to know how to respond to subpoenas, be familiar with applicable state and federal laws and regulations, and secure documentation for future access.

Acquire Legal Know-How. Perhaps the most frequent trigger for the disclosure of documents is the subpoena. A *subpoena duces tecum* requires a party who is in control of relevant documents to bring them to a deposition or court hearing. Social workers should not confuse subpoenas to **appear** with documents with an order to **disclose** the documents' contents. Subpoenas and court orders are entirely different phenomena. In fact, the NASW *Code of Ethics* (1996) obligates social workers to take steps to protect the confidentiality of relevant documents during legal proceedings:

> Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. (Standard 1.07[j])

Social workers should not release any confidential information contained in documents unless they are sure they are authorized to do so—based on client consent or in response to a court order, for example (Polowy & Gorenberg, 1997).

Know Relevant Statutes and Regulations. There are many federal and state statutes and regulations that govern the handling of confidential documents (Dickson, 1998). For example, the federal Health Insurance Portability and Accountability Act, or HIPAA (P.L. 104-91), and its regulations address the protection of personal health-related information. Clinical social workers should be especially familiar with explicit HIPAA provisions that are unique to psychotherapy notes. The regulations define these specifically as 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.

Other key federal regulations govern the handling of confidential documents related to alcohol and substance abuse treatment (42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records) and school records (34 C.F.R. Part 99, the Family Educational Rights and Privacy Act, or FERPA). States also have specific laws and regulations governing the release of confidential documents contained in health, mental health, school, and child welfare records (Dickson, 1998).

Secure Records. Social workers should store records (clinical, personnel, supervisory, and administrative) in secure locations to prevent unauthorized access (Barsky & Gould, 2002). When using electronic media, practitioners should exercise caution to ensure that this information cannot be accessed by unauthorized parties (see NASW *Code of Ethics*, standards 1.07[l],[m]). Social workers should consult relevant federal and state statutes, regulations, codes of ethics, and contracts (for example, insurance company and managed care contracts) to determine the length of time that documents should be retained. If and when records are destroyed or disposed of, care must be taken so that the disposal still protects client confidentiality (Barsky & Gould, 2002; NASW, 1996).

CONCLUSION

Social workers' understanding of the relevance of documentation has dramatically evolved. Once a simple theory building, research, and teaching tool, documentation has transformed over time to incorporate detailed and sophisticated standards for clinical and other direct practice settings. As social workers navigate a new landscape of practice, enhanced service delivery requirements, and fast-paced technological innovation, documentation for risk-management purposes has risen in importance.

To comply with current ethical and legal standards and to protect clients and themselves, social workers should conduct thorough assessments of their documentation policies and procedures. Independent and private practitioners, who do not need administrative approval, are in a position to modify their own documentation policies and procedures to comply with prevailing standards. Social workers who are employed by agencies may have less authority to make needed changes; they can share their concerns about documentation policies and procedures with administrators and advocate for change. SW

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***Frederic G. Reamer, PhD**, is professor, Rhode Island College School of Social Work, 600 Mt. Pleasant Avenue, Providence, RI 02908; email freamer@ric.edu.*

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