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Health Information Compliance Alert

Privacy: For Mental Health Care, Let Cooler Heads Prevail With Patient Notes

A 3-Step Process To HIPAA-Compliant Psychotherapy

While HIPAA doesn't require providers who offer mental health services to disclose psychotherapy notes to their patients, that won't stop many of their patients from demanding them anyway. Advance planning can help providers respond to patients who cry, 'Show Me the Notes!'

So, what exactly are "psychotherapy notes"? HIPAA's privacy rule (164.501) defines them as an official record, created in any medium by a mental health professional for purposes of treatment, of "the contents of conversation during a private counseling session or a group, joint or family session that are separated from the rest of the individual's medical record."

Clinical psychologist and president of the **American Mental Health Alliance-Oregon** in Portland, **Michaele Dunlap**, explains it this way: "'Psychotherapy notes' are the idiosyncratic jottings of the individual therapist."

Perhaps it's simpler to define "psychotherapy notes" in terms of what they're not. They can't be anything "materially relevant to the therapy," says Dunlap. "Any information that's commonly shared in training, in consultation with other clinicians, that's a summary of symptoms, diagnosis, treatment plan, or process of treatment - all of those are not psychotherapy notes," she continues.

Of course, none of this is likely to impress a patient who wants to see them. "Telling a patient you don't have any notes because you wrote only 'psychotherapy notes' is not going to satisfy them and would probably provoke them," warns **Ed Zuckerman**, clinical psychologist in Armbrust, PA and author of HIPAA Help: A Guide to Record Privacy and Security Under HIPAA. Instead, therapists should follow a three-step plan to ensure they're prepared when a patient says, "Show me the notes!"

1. Don't write down anything you wouldn't want the patient to see. In most cases, your notes won't provide the patient with much new information. Your patient already has a right to view his own chart - and your notes probably won't tell him more than the chart already does. But by writing down only things you'd be comfortable showing the patient, you avoid a confrontation before one even exists.

In some cases, though - such as those involving particularly difficult, contentious, or disturbed clients - even the most judiciously written notes might still present a problem. These are probably the same cases in which you already have larger concerns about the practitioner-client relationship. "The only time I wouldn't show a client a note is when I'm treating someone so character-disordered that I'm believing that person's going to come after me in a lawsuit," Dunlap insists. If that's the case, she says, document your suspicions explicitly, keep those notes separate from the client's regular file, de-identify them, and don't mention their existence to the client.

2. Find out what the patient really wants. In most cases, says Zuckerman, who is also the author of The Clinician's Thesaurus, the patient doesn't even really want the notes - he wants information. "He wants to know if there was some secret he told you that he's forgotten. He wants to know if you have some insight you didn't share with him" but instead wrote in your notes.

Talk with him, Zuckerman counsels. If you're too high-handed and refuse to discuss the matter, he cautions, the patient might become so frustrated he goes to a lawyer. Don't forget, he adds, psychotherapy notes are discoverable in

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litigation. So even if you refuse the patient's request, you won't be able to refuse the court's - and the patient will ultimately get his way. "It's probably better to head it off with a discussion before that," Zuckerman concludes.

3. Offer the patient a summary of your notes. Are your notes even intelligible? "Most people's notes aren't readable - and even if they are they might be misunderstood," Zuckerman observes. After all, Dunlap reminds, the personal, idiosyncratic nature of psychotherapy notes is precisely what distinguishes them from the rest of the medical record. For that reason, she adds, a valid initial response to the inquiring patient would be, "Sometimes I make scribbling for my own memory and it wouldn't make sense to anyone but me."

If that doesn't mollify the patient and you think your discussions with the patient have clued you in to what he wants, you should consider summarizing your notes and offering the summary instead, Zuckerman suggests. Write a summary and ask the patient to agree to accept it in lieu of the original notes. This approach satisfies HIPAA and should do the same for the patient, Zuckerman says.

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