Standards
respecting the keeping of record and consulting offices

For members of the Ordre professionnel des travailleurs sociaux du Québec

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Foreword

In accordance with its mandate to protect the public, the Ordre professionnel des travailleurs sociaux du Québec (the Order) must ensure that its members practice their profession in a competent manner. More specifically, the Order must ensure that social workers and marriage and family therapists uphold and develop the quality of their professional activities, and must provide them with the means necessary to achieve this objective. Record keeping is one of these essential professional activities, because it guarantees the client that the confidential nature of the private information is respected, and ensures the quality and continuity of the services provided.

The current context surrounding the practice of the profession of social worker and marriage and family therapist is extremely complex, and involves tangible challenges towards the activity of record keeping. These challenges include interdisciplinarity, which is a method of providing health and social services that is very prevalent among the establishments that make up the public health system; the introduction of integrated service networks combined with the reconfiguration of health and social services establishments; and the implementation of new information technologies in the area of managing personal information related to health and social services.

These continuously evolving transformations have a direct impact on the responsibilities of social workers and marriage and family therapists, who must record information in their client records on a daily basis. This information is highly confidential, and is often essential to the physical and mental well-being of their clients.

In order to guide and support social workers and marriage and family therapists in the performance of their professional obligations, the Order has developed these **Standards respecting the keeping of records and consulting offices.** These standards explain the obligations that are stipulated in the laws and regulations that govern the activities of social workers and marriage and family therapists. The objective is to promote thoroughness and quality with respect to record-keeping activities.

These standards are not legal provisions as such. However, they define the professional obligations that result from the laws, and therefore, they can be characterized as being imperative, because they serve as a referential framework with respect to ongoing training, professional inspection, and disciplinary investigations, and with respect to fundamental student training.

These standards may serve as a reference for a number of stakeholders, including the establishments that make up the health and social services system and any other organization or company that employs professionals who are members of the Order. They may also serve as the basis for discussions when seeking to work in harmony with other professional orders whose members often work in collaboration with social workers or marriage and family therapists.

For the optimal use of the Standards respecting the keeping of records and consulting offices.

The Standards respecting the keeping of records and consulting offices apply to every environment within which social workers and marriage and family therapists practice, including public establishments, private practice, and community organizations. They do not favour a particular theoretic framework, a specific approach, or a unique intervention method.

This document was designed for easy reference by social workers and marriage and family therapists. The statement of each standard is followed by a definition of its main concepts, and recommendations formulated by the Order for the practice of the profession. These recommendations rely on a number of legal and regulatory sources, and the primary sources for each standard have been transcribed, starting on Page 94.

Although the definitions and recommendations were specifically developed for each of the seven standards, it is important to understand that these standards are closely inter-related and interdependent. For example, Standard I, which sets forth the obligation to keep a record for each client, is completed by Standard V, which describes the contents of the records. A glossary has been included at the end of the document in order to facilitate the retrieval of information concerning a specific theme or concept.

Finally, it is important to note that the references to sections of the *Code of ethics of members of the OPTSQ* and other regulations pertaining to the Order mention only social workers as the intended professionals. Sections 13, 16, and 17 of the *Decree respecting the integration of marriage and family therapists into the Ordre professionnel des travailleurs sociaux du Québec* specify that all of these regulations also apply to marriage and family therapists.

Standard I:

Records

The social worker or marriage and family therapist must keep a record for each client.

Main definitions associated with the standard

Nature of a record

A record is a document with legal value that contains all information pertaining to a client who requests and receives professional services, as well as all information pertaining to these services.

The record is the property of the client or the user. The professional, the establishment, or the organization is the legal guardian of the record, but not the owner.

The medium used to record the information varies. It may constitute a paper document, an electronic document, a tape, a diskette, a compact disc, a microfilm, or any combination of these media.

Objectives of the record

The primary purpose of the record is to:

- ensure the client's rights to access the information that pertains to him, the rectification of specific information, the respect for his privacy, and the respect for professional secrecy;
- ensure the continuity, quality, and coherence of the services provided to the client;
- attest to the services rendered by the professional, and to provide concrete proof of action taken;
- satisfy requirements pertaining to the evaluation of the quality of services, the allocation of resources, research, and education;
- respond to various legal requirements, especially those related to professional inspection and disciplinary investigations.

Client

A client is any individual, couple, family, group of people, organization, community, or society for which the social worker or marriage and family therapist renders services or performs professional activities. These services may be rendered at any type of private or public establishment, community organization, or non-profit organization, or in private practice.

User

A user is any individual who receives the services provided by an establishment within the health and social services system.

Depending on the type of establishment, the concept of user will be more or less specific. In a Centre de santé et de services sociaux (CSSS), any adult or child who receives health or social services is considered to be a user. However, at a hospital centre (HC), only the person who receives medical services is considered to be a user.

Therefore, a person can be both a user at an establishment and the client of a social worker or marriage and family therapist.

Family member

A family member is any person who has family ties with the client, such as a child, a parent, a spouse, a sibling, or a grandparent.

It is possible that the user's family member will also be a client of the social worker or the marriage and family therapist.

Significant person

A significant person is any person who has a preferred tie (other than a family tie) to the client, who works in the client's interests, and to whom the social worker or marriage and family therapist has recourse in the provision of services.

Collaborator

A collaborator is anyone who works with the social worker or the marriage and family therapist in order to provide a client with services, including volunteers, family resource workers, or other such individuals. A professional or co-worker with whom the social worker or marriage and family therapist works for an evaluation or intervention is not considered to be a collaborator for the purposes of record-keeping.

Recommendations pertaining to professional conduct

At public establishments

As a general rule, records that are created for the users of an establishment are deemed to be the records in which the social worker or marriage and family therapist records all of the elements listed in the *Regulation respecting the keeping of records and consulting offices by members of the OPTSQ* (Sections 3 and 8).

The professional is not responsible for creating the record, but he must follow the administrative by-laws stipulated by the establishment with respect to the physical content of the record, specifically in terms of the format and structure of the record (sections, tabs, forms, etc.)

- In the case of a Health and Social Service Centre (CSSS)[1], there is usually a single record created for each adult or child user who receives health or social services. If the social worker or marriage and family therapist offers services to a user, this user becomes a client, and the professional must record all of the required information in this user/client's record.
  If the social worker or the marriage and family therapist offers psychosocial services and implements an intervention plan for one of the user's family members, this family member becomes a client, and a record must be created in the name of this client.

  No record is created for a significant person or a collaborator.

- In the case of a **Hospital Centre (CH),** there is usually a single record created for each user who is "admitted", "registered", or "signed in", or in other words, any user who receives **medical care**. If the social worker or marriage and family therapist **offers psychosocial services to a user**, this user becomes a client, and the professional must record all of the required information in this user/client's record.

  If the social worker or the marriage and family therapist offers psychosocial services and implements an intervention plan for **one of the user's family members**, this family member becomes a client, and a record must be created in the name of this client. It is possible that this record will be considered to be a part or component of the user's record at the establishment, in order for it to be quickly removed when requests for access are made. If the record is created in the name of a child, and the parents of the child are clients of the social worker or the marital or family therapist, it is recommended that a record be created for each parent, or that a "parents" record be
  Created and inserted as a component of the child's record.

  No record is created for a **significant person** or a **collaborator.**

- In the case of a **Residential and Long-Term Care Centre (CHSLD) or a Rehabilitation Centre (CR)**, there is usually a single record created for each user who receives accommodation and

[1] Note. At the time when these standards were published, the Proposition de dénomination des installations des centres de santé et de services sociaux, which was published by the Direction générale de la coordination et la Direction des communications du Ministère de la santé et des services sociaux in July 2005, had not yet taken effect. Once it does, necessary amendments will be made in the public system, according to a variable schedule for each administrative region.

rehabilitation services. If the social worker or marriage and family therapist **provides a user with psychosocial services,** this user becomes a client, and the professional must record all of the required information in this user/client's record.

If the social worker or the marriage and family therapist offers psychosocial services and implements an intervention plan for **one of the user's family members**, this family member becomes a client, and a record must be created in the name of this client

If the social worker or marriage and family therapist works in cooperation with an intermediary resource respresentative or a family resource representative with the framework of services offered to a user, this representative becomes a **collaborator.** A specific record must be created in the name of the collaborator. This record must be distinct from the user's record, and must take into consideration the nature, the scope, and the frequency of the professional contact between the social worker of marriage and family therapist and the collaborator.

No record is created for a **significant person.**

- In the case of a **Youth Centre (YC)**, there is usually a single record created in the name of each child to whom the establishment provides services in accordance with the *Youth Protection Act* (YPA), the *Act respecting health and social services* (*ARHSS*), or the *Youth Criminal Justice Act* (YCJA). In the case of a YC, a user is defined as *"any person (youth or parent) to whom the establishment provides services"*[2].

Within the context of the application of the YPA and the YCJA, **the child user** and **the parent user** are clients of the social worker or the marriage and family therapist, and this professional must record all of the required information in the record created for the child. In such a case, information that relates to the parents is not considered to be information related to third parties (except for the purposes of applying the rules respecting access to records). **In private practice**

The social worker or marriage and family therapist must create a record for each client to whom professional services are offered, or in other words, for each individual and for each member of a couple, family, or group.

At community organizations

The social worker or marriage and family therapist must create a record for each client to whom professional services are offered, whether or not the client is a user of the organization's services or a family member of a user for whom an intervention plan has been implemented.

No record is created for a **significant person** or a **collaborator**.

Conditions respecting specific interventions
(At public establishments, in private practice, and at community organizations)

For an intervention with a couple or family, and for marital and family therapy

In order to enable the professional to compile notes and reports in such a manner as to effectively reflect the clinical process and to avoid repetitions that could lead to confusion and result in errors, it is recommended that:

- *a record be created for each member of a couple or each member of the family, and that the nominative information required pursuant to Section 3, paragraphs 1 and 2 of the Regulation respecting the keeping of records and consulting offices by members of the OPTSQ be included in the record, along*

[2] Association des centres jeunesse du Québec: *Cadre de référence sur les dossiers des usagers,* March 1996, p. 5.

with any report that relates to an individual intervention;

- *with the consent of each member of the couple or family, one record be designated to include all notes and reports related to marital or family intervention or therapy. In such a case, it is important to include the consent obtained from each person;*

- *non-designated records include a notation that indicates the location where the reports related to marital or family intervention or therapy are kept;*

- *the record of each member of the couple or family include a notation concerning the individual's presence or absence at each session, along with any other information relevant to the marital or family intervention or therapy;*

- *reports related to this type of intervention be clearly identified in such a way as to ensure that no other reports that relate to an individual intervention involving a member of a couple or family are accessible to a third party*;

- *the names of the people who are present at meetings be carefully recorded, in order to establish subsequent rights to access.*

For a group intervention

It is recommended that:

- *a record be created for each member of the group, and that the record include the required information and all reports related to an individual intervention, and especially the psychosocial evaluation and the intervention plan, a notation concerning the group member's presence or absence at each session, as well as any other information that relates to the group intervention;*

- *a group record be created, and that this record include all reports related to the actual group intervention, especially the name of the group, the pre-group evaluation, the intervention plan or proposal, chronological notes, and the summary of activities;*

- *the nominative information related to each member in the group be entered in the group record, with the consent of each member.*

For a community intervention

It is recommended that:

- *a project record be created, and that this record include all documents related to each project that attest to the professional acts specific to this type of intervention.*

For the supervision of a student or colleague

The standards that comprise the framework for the professional activity of supervising a student or colleague and define the associated responsibilities have not yet been developed. Therefore, at the present time, it is recommended that:

- *a supervision record be created in the name of the student or the colleague;*

- *this record include notes and other documents related to the supervision process (including the objectives, the supervision contract, the evaluation of the supervised individual, etc.).*

- *no nominative information related to the clients of this student or colleague be included in this record. The use a coding system (initials, numbers, etc.) is sufficient in order to follow the progress of the supervised records.*

Standard II:

Confidentiality and professional secrecy

The social worker or marriage and family therapist must ensure the confidentiality of personal information and respect for professional secrecy.

Main definitions associated with the standard

Client's rights

The concept of confidentiality

The fundamental right to privacy is a recognized human right at the international, federal, and provincial levels.

The Québec Charter of Human Rights and Freedoms affirms the absolute right of the individual to respect for his private life. In terms of health and social services, all of the information contained in the records of the users of these services is considered to be confidential, and the establishment is obligated to implement the necessary measures to protect the confidentiality of these records.

The concept of professional secrecy

Respect for professional secrecy forms the very foundation of the trust relationship between the client and the professional.

The right to professional secrecy is secured by Section 9 of the *Québec Charter of Human Rights and Freedoms*, which binds the professional with the duty to protect this right. Pursuant to Section 3.06.01 of the *Code of ethics of members of the OPTSQ,* the social worker or marriage and family therapist cannot disclose any information that is divulged by a client or any information concerning a client that is obtained during the practice of his duties unless the client consents to the disclosure or unless the disclosure is ordered by law or by a judge.

The concept of consent

From now on, the term "consent" will replace the term "authorization" in all of the sections of law that relate to the authorization of the user or the client to transmit information, to provide access to his record, or to receive care or services. Therefore, wherever the term "authorization" is used in the *Code of ethics of members of the OPTSQ*, it should be understood as the "consent" of the client.

There are three types of consent:

I ***Consent to transmit information to a third party (including consent on behalf of a minor)***

II ***Consent to provide access to a record (including consent on behalf of a minor)***

III ***Consent to receive care or services (including consent on behalf of a minor)***

Validity of the consent

In every milieu, obtaining consent is an essential step in the practice of the profession of social worker or the marital or family therapist, and it provides a gauge of the client's respect and willingness with respect to his private life and the decisions that he makes for himself.

In order to guarantee validity, certain conditions must be in place for each type of consent:

- *The consent must be **manifest:** a clear and explicit gesture (preferably written consent) indicates that the client is aware that he is consenting.*
- *The consent must be **free**: with no pressure or discrimination on the part of the professional, the client is able to give consent with full confidence.*
- *The consent must be **enlightened**: having received all appropriate and necessary information, and having been informed of the consequences of the consent, the client is able to give consent with full awareness of the ramifications.*
- *The consent must be given **for specific purposes, and for a limited time**: having received an explanation of the reasons for transmitting the information, for accessing the record, or for the care that will be provided, as well as the*

duration of the consent, the client is able to understand why he is consenting, and for how long.

Exceptions to consent

Exceptions to consent are stipulated in the laws relating to the transmission of personal information for a number of reasons, and primarily to ensure the safety of individuals.

Some of these exceptions are the responsibility of public establishments and organizations.

Others relate to the responsibility of the professional, who may, or in certain cases, must transmit information without the client's consent, specifically:

- ***To prevent an act of violence, including suicide,*** *if he is of the opinion that there is an imminent threat of death or serious injury to an individual or identifiable group of persons (Section 3.06.01.01 of the Code of ethics of members of the OPTSQ);*

- ***By order of a court*** *or a* ***coroner*** *in the exercise of the functions of office (Section 3.06.01 of the Code of ethics of members of the OPTSQ);*

- ***To report a child*** *to the Director of Youth Protection if he has reasonable cause to believe that the child's security or development is or may be compromised (Sections 38, 38.1, and 39 of the Youth Protection Act);*

- ***In reference to a reported child or a ward*** *of the Youth Protection Director if the latter requires the information in order to assume his youth protection mandate with respect to the child (Section 134 h of the Youth Protection Act);*

- ***In the case of an unfit adult person****, if the mandatary, guardian, curator, notary, or lawyer requires information for the application of the Public Curator Act or the Civil Code of Québec (Section 3.06.02 of the Code of ethics of members of the OPTSQ);*

- ***In the case of a deceased person****, if an heir, legal representative, or recipient of certain benefits requires information in order to validate his rights or responsibilities (Section 23 of the Act respecting health services and social services).*

Third party rights

Concept of a third party

A third party is any person other than the person in whose name the record was created (except in cases of youth protection, where the parent of the child who is identified and taken into custody is not considered to be a third party).

However, the concept of the third party excludes all health and social services professionals in the exercise of their functions.

The concept of confidentiality in relation to third parties

Information that is provided by a third party and recorded in the client's record is protected by confidentiality if the following conditions are present:

- *The information provided by the third party pertains to the user/client;*

- *Information contained in the record makes it possible to identify the third party;*

- *The third party has not consented, in writing, (or has refused) to the transmission of the information to the user/client.*

It is important to note that a health and social services professional who provides information pertaining to the user/client is not considered to be a third party. The information that he provides, including his identity, may become known to the user/client if this person asks for access to his record.

Recommendations pertaining to professional conduct

At public establishments, in private practice, and at community organizations

Respect for professional secrecy requires the social worker or marriage and family therapist to practice ethical vigilance in the performance of their professional activities, and to demonstrate an explicit willingness to clearly explain the constraints and limitations imposed by the context of the practice with respect to confidentiality to every client. For this reason, it is strongly recommended that the social worker or the marriage and family therapist inform his client, at an opportune time, of the operating methods of the establishment or organization where he practices his profession, and more specifically, of the interdisciplinary function of the care and service team and the sharing of certain information contained in the record among the various stakeholders for the purpose of ensuring the quality and continuity of care and services.

The social worker or marriage and family therapist must also assure his client that he will act according to the rules respecting consent in the case of any request for transmission of information, any request for access to the record, or any psychosocial or community intervention.

I. Consent to transmit information (including consent on behalf of a minor)

Regardless of the context, and regardless of whether the transmission of information takes place verbally, electronically, or in writing, the social worker or marriage and family therapist **must obtain at least the verbal consent of his client, and must include this in the record.** The professional must also ensure that he has obtained manifest, free, and enlightened consent from the client for a specific reason and for a limited time.

Even if verbal consent is adequate in light of ethical requirements, it is always infinitely preferable to obtain written consent from the client, particularly in more complex situations or those involving litigation. It is recommended that a form be used for this purpose that specifically indicates who the information is intended for, the content (or report) that is being transmitted, the purpose, and the duration of the consent (normally 30, 60, or 90 days).

A **Transmission of information between professionals at the same establishment or legal entity** (merged or integrated establishments) **or within the same organization.**

Professionals who practice within the same establishment or health and social services system or community organization can exchange information in the exercise of their duties without obtaining the client's consent. **Merged**[3] or **integrated**[4] establishments constitute new legal entities, and are considered to be single establishments. Therefore, the professionals can exchange information with other professionals within these new establishments without obtaining the client's consent.

B **Transmission of information outside of the establishment or the organization** (to another establishment, to another organization, to another professional, etc.) **or among a group of related establishments**.[3]

A social worker or marriage and family therapist must obtain the client's consent in order to transmit information. It is strongly recommended that the client's written consent be obtained (using a form intended for this purpose, or another document). The conditions for free and enlightened consent must be established. If the professional has

[3] **Merged** establishments: all of the establishments involved (for example the CLSC, the CHSLD, and the CH) legally disappear, and are replaced by a new establishment (the CSSS).
[4] **Integrated** establishment
s: the establishment that is integrated legally disappears, and only the integrating establishment remains.
[3] **Grouped** establishments share one and the same board of directors, but each retains its specific legal entity.

obtained the client's verbal consent, he must make a note of this in the record, along with the required information (the date, the intended recipient of the information transmitted, the reason for the transmission, and the duration of validity of the consent).

C Transmission of information without the client's consent.

The social worker or marriage and family therapist must act with extreme vigilance in situations where he is authorized to transmit information without the client's consent. He is fully accountable for his decision as to whether or not to transmit confidential information. He must carefully evaluate the ethical issues associated with making the decision, and he must note in the record all of the details pertaining to the circumstances under which the information is disclosed:

- *When issuing a warning concerning an act of violence or suicide, he must determine whether the situation threatens the life or safety of an identifiable individual (or a group of persons); he must determine whether there is an imminent danger of death or serious injury, or in other words, whether it is on the verge of occurring; he must notify the individual, his representative, or any other person who may be of assistance; he must only transmit the information that is required for the protection of the individual, and he must do so immediately; he must record the following information in the record as soon as possible: the reasons supporting his decision to convey the information, the identity of the person who reported the danger (if applicable), and the identity of any person who is exposed to danger; and he must record the date and time when the information was sent, the contents of the communication, the method of communication used, and the identity of the person contacted;*

- *When alerting the YPD, the social worker or marriage and family therapist must transmit the information that is required to enable the YPD to evaluate the alert;*

- *In the case of a minor who is under the protection of the YPD (in the evaluation or orientation step), the social worker or marriage and family therapist must verify the identity and position of the employee who is requesting the information, and may transmit only the information that is relevant to the situation;*

- *In the case of an unfit adult person, the social worker or marriage and family therapist must ensure that a third party that requests information needs this information in order to perform the duties entrusted to him by law (e.g.: the mandatary);*

- *In the case of a deceased individual, certain specific conditions must be met in order to enable the transmission of information: the legal heirs or testamentaries, the legal representative, or the beneficiaries of certain services can obtain information, but only if it is necessary in order for them to exercise their rights. The mere fact of being an heir does not entitle a person to obtain information. The social worker or marriage and family therapist must verify the person's identity, his status in relation to the deceased person, and the reason why the information is being requested. In light of the fact that there are several complex legal aspects that must be known in these cases, it is recommended (especially for a social worker or marriage and family therapist in private practice) that these aspects be understood before any information is transmitted.*

D Transmission of information provided by a third party

Regardless of the context of the practice, it is necessary to obtain written consent from the third party in order to transmit the information that he provided concerning the client, including his identity. If he refuses to give his consent, this information cannot be transmitted to the client, or to any other person.

It is important to note that information provided by a third party in the presence of a user/client is not considered to be

confidential, and can be transmitted to the user/client without the consent of the third party.

E Transmission of information pertaining to a minor under the age of 14

The person who is in a position of parental authority is the person who must consent to the transmission of information pertaining to a minor, subject to the conditions necessary for the validity of the consent, as explained earlier. For the purposes of consenting to the transmission of information, either parent is deemed to be acting on behalf of the other. In general, only the consent of one of the two parents is required in order to transmit information. There are certain exceptional situations, which are explained in **Section III, Consent to receive care and services**.

F Transmission of information pertaining to a minor over the age of 14

Only a minor over the age of 14 may consent to the transmission of information. The social worker or marriage and family therapist cannot inform the parents of a youth of any request for information unless the youth consents to this. Several exceptions are provided for in the *Youth Criminal Justice Act.*

G Transmission of information by electronic mail or by fax

At public establishments

Electronic mail

Public establishments are responsible for subjecting themselves to a series of measures that ensure the security of their information-based assets. The social worker or marriage and family therapist who works at such an establishment must adhere to the establishment's guidelines with respect to electronic documents and transfers. The professional must also ensure that he has the client's consent, according to the same conditions that apply to the transmission of paper documents.

Fax

A fax machine must be installed in a supervised location that is not accessible to the public and that is only used by authorized individuals.

More specifically, the social worker or marriage and family therapist must:

- *carefully verify the recipient's fax number, and ensure that the recipient (or another person whom he has designated) is present to receive the document;*
- *obtain confirmation of receipt of the document;*
- *clearly indicate the confidential nature of the personal information that is transmitted.*

In private practice and at community organizations

Electronic mail

In light of the risks associated with electronic transfers, a social worker or marriage and family therapist cannot use electronic mail to transmit confidential reports. The use of electronic mail is possible **only if the social worker or marriage and family therapist puts into place appropriate and up-to-date technological security mechanisms in order to ensure the confidentiality, integrity, and authenticity of the electronic transfer.** In addition, the professional must inform his clients of the means that have been implemented in order to counteract the risks associated with the use of electronic mail, and must obtain the client's consent, in accordance with the same conditions that apply to the transmission of paper documents.

Fax

A fax machine must be installed in a supervised location that is not accessible to the public and that is only used by authorized individuals.

More specifically, the social worker or marriage and family therapist must:

- *carefully verify the recipient's fax number, and ensure that the recipient (or another person whom he has designated) is present to receive the document;*
- *obtain confirmation of receipt of the document;*
- *clearly indicate the confidential nature of the personal information that is transmitted.*

II. Consent to provide access to records (including those of a minor)

This type of consent is particularly complex, and involves a number of legal elements.

Concepts pertaining to access rights and recommendations pertaining to professional conduct are explained in **Standard III.**

III. Consent to receive care and services

At public establishments, in private practice, or at community organizations

The social worker or marriage and family therapist must obtain his client's free and enlightened consent before proceeding with any intervention:

- *The professional must inform the client of the nature of the services that will be offered to him, and the avenues for recourse that exist in the event that he is not satisfied;*
- *The professional must inform the client of the foreseeable consequences of the services that are offered, especially with respect to the sought or desired changes, and the possible impact of the proposed intervention (on the client and his family members);*
- *The professional must inform the client of the foreseeable consequences of refusing the services offered, and must offer the client a choice between the proposed intervention or treatment and the absence of the proposed intervention or treatment;*
- *The professional must inform the client of alternatives to these services, such as consulting other professionals or opting for other services;*
- *The professional must ensure that the client understands the information provided, by offering explanations in everyday language, clarifying technical terms, and taking into consideration the client's personal and cultural background;*
- *The professional must not impose any constraints on the client, either psychologically or otherwise, must not apply direct or indirect pressure, and must ensure that no other person imposes such constrains.*

In situations involving imposed services, and particularly in the context of correctional services or those stipulated under the terms of class legislation such as the *Youth Protection Act* or the *Youth Criminal Justice Act* or the Criminal Code, the client's free consent may be more restricted. However, the social worker or marriage and family therapist is required to inform the client of the nature of the interventions and the foreseeable consequences of the interventions in everyday language that is adapted to the client's personal and cultural background.

Consent to care and services for a minor

The matter of obtaining consent from parents in order to carry out a psychosocial or other intervention involving a child depends on whether the child is under or over the age of 14, or whether the situation involves the protection of a minor.

A A minor under the age of 14

Consent of the person having parental authority (*Civil Code of Québec, Section 18)* is required for any psychosocial

intervention involving a child under the age of 14 (psychosocial evaluation, social intervention), or for a therapy (individual or family treatment). **When the two parents live together** and both have parental authority, the consent of one of the parents is presumed to be sufficient in order to provide professional services for a minor who is under the age of 14 (*Civil Code of Québec, Section 603).*

However, it is recommended that the social worker or the marriage and family therapist explain the role of the professional, the reasons, and the means chosen for the intervention involving the child to both parents.

In a case where the parents are separated or divorced, both parents generally retain their parental authority, and unless there has been a legal forfeiture of parental rights (in which case only the consent of the parent having parental authority is necessary), the father or the mother who consents alone is presumed to be acting with the consent of the other parent (*Civil Code of Québec, Section 603*). If the social worker or marriage and family therapist has no valid reason to believe that one of the parents would oppose the provision of professional services involving the child, he may proceed with an intervention involving the child with the consent of only one parent. However, in light of the frequency of conflicts between parents who are separated or divorced, and the fact that the social worker or marriage and family therapist may be caught in the middle of such conflicts, it is recommended that the written consent of both parents be obtained under these circumstances, except in cases where doing so could be harmful to the child.

If the person having parental authority (either of the parents) categorically refuses the provision of psychosocial services that are required by the child's state of health, and this refusal is unjustified or frivolous, the other parent may address a court in order to have a judge authorize the intervention. The establishment that provides these psychosocial services may also send a request to the court.

B For a minor over the age of 14

Only the consent of the minor is required for a psychosocial intervention (psychosocial evaluation, social intervention), or for a therapy (individual or family therapy). If the minor over the age of 14 refuses the provision of psychosocial services that are **not required** in order to treat his state of health, the parents may petition the court to authorize the intervention.

If the minor over the age of 14 refuses the provision of psychosocial services that are **required** to treat his state of health or to ensure his integrity, the court's authorization must be obtained.

If it is an **emergency situation**, the consent of the person having parental authority is sufficient.

C Situations where the protection of the minor child (under the age of 18) is compromised

Parental consent is not required in order for the social worker or marriage and family therapist to carry out an evaluation and proceed with an intervention in the case of a minor child whose security or development is considered to be in danger within the meaning of Sections 38 and 38.1 of the *Youth Protection Act.*

In fact, Section 39 of the *Youth Protection Act* stipulates that every professional who, by the very nature of his profession, provides care or any other form of assistance to a child and who, in the practice of his profession, has reasonable grounds to believe that the security or development of the child is or may be considered to be in danger within the meaning of Sections 38 or 38.1, must bring the situation to the attention of the Youth Protection Director without delay, professional secrecy notwithstanding.

Standard III:

Access to records

The social worker or marriage and family therapist must grant the client access to his record and must refuse access to any other person, unless the client gives his consent or the law stipulates exceptions.

Main definitions associated with the standard

The concept of the right to access a record is closely related to the concept of consent, which is explained in **Standard II.** It is important to refer to Standard II in order to complete the concepts covered in Standard III.

The client's right to access his record

On principle, only the client has access to his record. This is a right that belongs to him alone, and he cannot waive this right without giving his explicit consent.

Only a minor under the age of 14 does not have the right to access his record.

The right to access the record also entitles the client to other ensuing rights:

- *The right to receive assistance with respect to explanations concerning the contents of the record;*
- *The right to receive a copy of the entire record or the reports contained in the record upon request;*
- *The right to request that inexact, incomplete, or ambiguous information in the record be corrected, and to request that outdated information or information that is not justified by the contents of the record be removed;*
- *The right to add written comments to the record.*

Refusal of access to the record

The law stipulates the circumstances under which a professional may refuse to grant the client access to his record. These circumstances are restrictive, and cannot be interpreted broadly. The only circumstances that may justify the refusal of access to the record are:

- If the client's reading of the record may cause severe harm to the client's health

or

- *If the client's reading of the record may cause severe harm to a third party or may reveal information concerning the third party without this person's consent.*

Exceptions pertaining to access to records

Although only the client has access to his record, there are certain exceptions, primarily in order to allow certain people to exercise their rights and responsibilities, to allow for the disclosure of certain information during investigations, and to ensure the continuity and quality of health and social services.

The following individuals have access to the record:

- *A third party (for example, a family member or a loved one)* ***only if the client consents to this****;*
- *The professionals of a health or social service establishment, to the extent that this is required by the execution of their duties;*
- *The parents (or persons having parental authority) of a child under the age of 14;*
- *The parents (or persons having parental authority) of a child over the age of 14,* ***only if the child consents to this and it is determined that this will not cause any harm****;*
- *The Youth Protection Director during the course of his duties, in accordance with certain terms stipulated in the Youth Protection Act;*
- *The guardian, curator, or mandatary of an unfit adult person, to the extent that this is required by the execution of his duties;*
- *The heirs, guardians, or recipients of benefits of a deceased individual,* ***only if this is required in order for them to exercise their rights and responsibilities, and if the deceased***

person has not explicitly refused access to his record.

In addition, the law requires access to records for certain situations, namely:

- *A coroner's inquest;*
- *An investigation by the Commission des droits de la personne et des droits de la jeunesse;*
- *A subpoena;*
- *A professional inspection by a professional order;*
- *A disciplinary investigation by a professional order.*

Recommendations pertaining to professional conduct

Request to access a record

At public establishments

Any request for access made by a user/client or a third party must be forwarded to the person who is designated by the establishment as being responsible for access. Working with the archivist for the establishment, this person must manage the access procedure, and must ensure that the person who requests access to the record has the right to this access. The establishment must respond to the request for access within 20 days following receipt of the request.

The user/client has the right to receive explanations concerning the contents of the record, and therefore, the person responsible for access may ask the social worker or marriage and family therapist to provide the client with appropriate explanations concerning the contents of the psychosocial reports or marital or family therapy.

Access rights are governed by administrative by-laws that the social worker or marriage and family therapist must follow.

If the professional is of the view that the client's rights are not being respected by these rules, he must advise the competent authorities.

In private practice and at community organizations

If the client requests access to his record, the social worker or marriage and family therapist must grant him access to the complete record, and must conform to the following requirements:

- *The social worker or marriage and family therapist must grant the client access to the record in his presence (or in the presence of someone whom he delegates);*
- *Access to the record must take place during business hours, at the social worker or marriage and family therapist's office or consulting office;*
- *The social worker or marriage and family therapist must provide the client with necessary and appropriate explanations concerning the contents of the record;*
- *The professional must not remove any document or report from the record at any time;*
- *At the request of the client, the professional must provide a copy of the record or of a section of the record at no cost, with the exception of photocopy expenses, if applicable;*
- *If the record or reports are computerized, the social worker or marriage and family therapist must make a paper copy in order to facilitate reading;*
- *The response to the request for access must be diligent, or in other words, it must not take longer than 30 days following receipt of the request.*

If a third party requests access to a client record, the social worker or marriage and family therapist must determine whether this person has access rights.

In order to do so, he must request supporting documents for the following purposes:

- *In order to verify the person's identity;*
- *In order to confirm that this person is authorized by the client (client consent form), is the guardian, curator, or mandatary of an unfit person, or is the heir of a deceased person and has a right or responsibility to be exercised.*

Request to correct or remove certain details

At public establishments

Any request to correct or remove certain details of the record of a user/client must be sent to the person who is designated by the establishment as being responsible for access. This person may consult the social worker or marriage and family therapist concerning the relevance of correcting or removing certain details.

However, the social worker or marriage and family therapist must conform to the administrative by-laws stipulated by the establishment in this respect.

In private practice and at community organizations

The social worker or marriage and family therapist must ensure that the request is justified, and that the requested amendments do not misrepresent the professional's opinion or recommendations.

It is recommended that the social worker or marriage and family therapist ask the client to submit a written request for correction of the information that he deems to be inaccurate, incomplete, or ambiguous, or for removal of the information that he would like to have deleted because it is outdated or not justified by the contents of the record. The social worker or the marriage and family therapist is not required to amend his professional opinion or recommendations in response to a request from the client.

If the professional makes the requested corrections or modifications, he must give the client a copy of the amended document (at no charge) and a certification that the client's written comments were added to the record. He must also send a copy of the document (at no charge) to any person from whom he received this information or to whom he transmitted this information. All of these steps must be meticulously noted in the record.

The same procedures apply if the record is computerized, or if the client is requesting correction of information contained in messages that were exchanged by electronic mail.

Refusal of access to a record

At public establishments

The person who is designated by the establishment as being responsible for access is the person who determines the circumstances under which access is refused. At the request of this person, the social worker or marriage and family therapist must be able to explain to the client, in writing, the severity of the damage that could be caused to his health if he were to become aware of certain psychosocial information that is contained in the record.

The social worker or marriage and family therapist must also conform to the administrative by-laws stipulated by the establishment concerning the refusal of access to a record.

In private practice and at community organizations

In addition to explaining to the client, in writing, the reasons for refusing access to the record (severe damage to his health), the social worker or marriage and family therapist must indicate the period during which the refusal will be in effect, and must inform him of the entities that he may contact if he does not agree with the decision, such as the Commission d'accès à l'information.

If information relating to a third party is included in the record, the social worker or marriage and family therapist must obtain the consent of this third party in order to grant the client access to his record. The client cannot access his record if the third party refuses.

However, it is possible to strike all information provided by the third party and all information that would make it possible to identify this third party from the copy of these reports, or to remove from the record any document in which information concerning the third party is included *(see Standard V, Contents of records)*. If the social worker or marriage and family therapist decides to proceed in this manner, he must do so with extreme vigilance.

Specifications pertaining to marital, family, or group intervention and marital, family, or group therapy

Only those people who attended interviews have the right to access the reports relating to the contents of said interviews.

If a member of a couple, family, or group requests access to the couple, family, or group record, and this person does not have the right to access the record, the consent of each member must be obtained in order for access to the record to be granted.

Access to a record ordered by law

At public establishments

Under all circumstances where the law orders access to the record of a user/client, the person who is responsible for the access to records will determine the procedure to be followed. If the social worker or marriage and family therapist receives a *subpoena duces tecum* that specifies that he must produce the user's/client's record in court, it is recommended that he consult the person who is responsible for accessing records at the establishment in order to determine how to proceed.

In private practice and at community organizations

Under all circumstances where the law orders access to the client record (including a *subpoena duces tecum*), the social worker or marriage and family therapist must produce the entire record, unless it is explicitly specified which reports must be produced. The removal of documents from the record is prohibited, and could result in a contempt of court charge or disciplinary action.

Standard IV:

Storing and keeping records

The social worker or marriage and family therapist must store records in such a way as to ensure their confidentiality, and must keep these records for at least five years following the last service rendered. Following this period, he may dispose of them in such a way as to maintain their confidentiality.

Main definitions associated with the standard

Storing records and keeping records are two concepts whose meanings are similar and complementary with respect to confidentiality.

Storing records

Storing records is the action (or actions) whereby the contents of records are kept intact and the relevance of the information contained in reports and other documents is preserved.

Storing records in accordance with certain rules is a basic principle underlying the concept of confidentiality, and is part of the foundation of the trust relationship between the client and the professional.

Keeping records

Keeping records is the action (or actions) whereby records are protected and access is granted to the appropriate people for a determined period of time.

Keeping records in accordance with certain rules is a principle that guarantees to the client that nobody will access his record without his consent, that the continuity of services will be maintained, that he can exercise his rights and recourse for five years after the last service is rendered, and that the personal information pertaining to him will be disposed of in complete confidentiality.

Recommendations pertaining to professional conduct

Storing records

At public establishments

The establishment is responsible for storing records, and more specifically, for:

- *designating the location where the records will be stored (normally in the archives);*
- *managing access to and the circulation of records.*

The establishment is also responsible for ensuring that the social worker or marriage and family therapist whom it employs has a locked room or piece of furniture (drawer or filing cabinet) that is not accessible to the public in which he can store his records. It is important to note that, at most public establishments, records must be returned to the archives each day.

If the social worker or marriage and family therapist must transport records outside of the establishment for reasons related to the performance of his functions (home visit, court testimony, move from one point of service to another), he must have a locked container in which to transport the records.

Some establishments have undertaken the partial or complete computerization of their records. In terms of preserving the authenticity and integrity of the information contained in the computer files, establishments are required to follow the rules stipulated in the Cadre de gestion pour la sécurité des actifs informationnels du réseau de la santé et des services sociaux.

A social worker or marriage and family therapist who works at a public establishment must inform his employer of his obligations with respect to storing records, and must notify the Order if he feels that he does not have the means at his disposal to conform to these obligations.

In private practice

The social worker or marriage and family therapist must keep records in the same place where he practices his profession, out of reach of the public, and in a locked filing cabinet or room.

If he uses a computer system, the social worker or marriage and family therapist must

take the following security measures, at the very least:

- *Prohibit access to the computer itself, especially if it is portable;*
- *Implement a technical method of preventing access to the software;*
- *Acquire a software that is designed in such a way that the information that is already recorded cannot be deleted or replaced.*

At community organizations

The social worker or marriage and family therapist must ensure that administrative by-laws conforming to the requirements of the Order serve as a guideline for the storage of records. If these specific by-laws do not exist, or if they do not satisfy all of the requirements of the Order, the social worker or marriage and family therapist must take measures to ensure the proper storage of the records.

Keeping records

At public establishments

Keeping records and the duration for keeping the records are the responsibility of the establishment's archivists. The social worker or marriage and family therapist who works at the establishment or who leaves his job is exempt from this obligation and must conform to the stipulated administrative by-laws.

In private practice and at community organizations

- *The social worker or marriage and family therapist must keep records for a period of at least five (5) years following the last professional service rendered (even in the case of a deceased individual).*
- *If a computer is used for the management of an active record, it is recommended that the record be transferred to another computer media, that a paper copy be made and placed in a file folder, and that the hard disk be erased;*
- *The social worker or marriage and family therapist must inform the client of the location where the record is being stored and how it can be accessed, if necessary. The client can locate the social worker or marriage and family therapist at any time with the help of the OPTSQ.*
- *If the social worker or the marriage and family therapist stops practicing the profession, either temporarily or permanently, he must appoint a temporary guardian or an appointee to store and keep his records, in accordance with the requirements stipulated in the Regulation respecting the cessation of practice of a member of the Ordre professionnel des travailleurs sociaux du Québec.*
- *If the social worker or marriage and family therapist leaves his job at a community organization, and if no adequate measure is taken to keep records, he must take the necessary measures to do this, and he must notify the Order.*

Disposing of records and work tools

At public establishments

The establishment bears the sole responsibility for disposing of records. The social worker or marriage and family therapist cannot dispose of records under any circumstances.

However, the social worker or marriage and family therapist is responsible for ensuring that his work tools are disposed of in a confidential manner, or in other words, that they are shredded. If the tools are computerized, he must completely erase the contents of the hard disk, diskettes, compact discs, or other computer media, including all recordings on any type of media whatsoever.

In private practice and at community organizations

The social worker or marriage and family therapist may dispose of his records after five years. In the case of paper records only, this means shredding them. If the record is computerized, the hard disk, diskettes, compact discs, or other computer media must be completely erased. The same applies to professional work tools, including recordings on any type of media whatsoever.

Standard V:

Contents of records and the drafting of notes and reports

The social worker or marriage and family therapist must record all information required for the purposes of the professional services rendered in the client record, and must ensure the objectivity and quality of the writing in notes and reports.

Main definitions associated with the standard

Records

A record is a legal document that details the interactions between the client, the professional, and the establishment or organization. It must contain certain information, which is identified in the various laws and regulations.

The record is also a document that attests to the professional's clinical process, which is outlined by the specific standards for practice for the profession of social worker or marriage and family therapist.

A record may be created for the following purposes:

- *If services are **requested** by the client from the professional, the establishment, or the organization;*
- *If services are **offered** to the client by the professional, the establishment or the organization;*
- *If services are **imposed** on the client within the scope of the application of a law.*

Reports, notes, and work tools

Reports and notes attest to the intervention process, and to the professional's opinion concerning the situation of the client to whom he is dispensing professional services.

Reports can have several recipients:

- *Most of the time, reports are added to the client's record for subsequent consultation by the client, by other professionals, or by the administration of an establishment;*
- *Reports may be drafted for the provision of specialized services, such as protective supervision of persons of full age, international adoption, family mediation, or expertise pertaining to child custody and visitation rights. They may also be drafted in order to ensure access to certain services, such as inter-establishment services, pedopsychiatric services, or long-term care ressources;*
- *Reports may be intended for agencies responsible for payment, such as the Commission de la santé et de la sécurité du travail, the Société de l'Assurance Automobile du Québec, and employee assistance programs;*
- *Reports may be intended for courts for the purposes of applying a law, such as the Youth Protection Act, the Youth Criminal Justice Act, and the Public Curator Act.*

Notes

Notes are short entries in the record that serve to ensure the continuity of services and as memory aids in connection with professional activities that are carried out. These short entries are generally chronological or progress notes.

Work tools

Work tools are items or documents (on paper or computer media) that the social worker or marriage and family therapist uses to develop his professional opinion, as memory aids for his thought process, for follow-up with respect to the intervention, or as a way to support the intervention process. These work tools are not intended for transmission to other persons, but instead, they are used to support the drafting of notes and reports.

Recommendations pertaining to professional conduct

Structure of the record

At public establishments

A record at an establishment can be stored on paper or on computer media, or as a combination of both types of media.

It may have various sections or components, or different coloured pages that distinguish the types of services rendered.

The record may also include subdivisions that are managed in more than one geographic location (or site); these subdivisions are not considered to be "parallel" or "satellite" records, because once they are reassembled, they constitute the client's/user's only record. The establishment is responsible for determining the structure of the records, taking into account its mission, organization, and available technology, and for establishing the administrative by-laws that must be respected.

As a general rule, it is recommended that the user's/client's record include a psychosocial component that contains the reports and other documents that are relevant to the social services rendered by social workers.

In addition, all of the professionals who offer services to a user must enter notes in the record when the services are rendered. These notes are entered in keeping with the conditions that are in effect at the respective establishments.

There are very few establishments where the user's record is completely computerized. At most establishments, the record contains certain types of documents or reports on computer media, and other forms, reports, and notes on paper. Regardless of the scope of computerization, all of the information, notes, and reports pertaining to the user/client that are contained on any form of media whatsoever are considered to be an integral component of the record.

In private practice

The record may be kept on paper (in a file-folder or otherwise), or on computer media.

The paper record must be kept by the social worker or marriage and family therapist, who must use it to store all of the reports and documents that are relevant to the services provided to the client.

These reports and documents must be classified by category, and must be in chronological order.

In addition, the social worker or marriage and family therapist must include a sheet or form for updating the progress of professional activities related to services rendered on a daily basis.

A computer record must comprise a single named file for each client, in which all reports, notes, and other documents must be stored, It is strongly recommended that the social worker or marriage and family therapist also keep a paper record for each client, in order to store all non-computerized documents, as well as a back-up of the client's file on diskette or compact disc.

At community organizations

The mission and structure of community organizations is very diverse. Therefore, it is not possible to provide an overall picture of the structure of records in this sector. In addition, the concept of a single record does not apply to community organizations. However, a social worker who is employed by an organization must at least structure client records (on paper or on computer media) according to the same rules that apply to private practice.

Contents of the record

At public establishments, in private practice, and at community organizations

The client record must contain the following information, at the very least:

Information pertaining to the client's identification[5]

[5] It should be noted that, at a public establishment, this information is entered in the user's record in such a way that the social worker

- *Last names and given names*
- *Address*
- *Telephone numbers*
- *Gender*
- *Date of birth*

Information pertaining to the client's request for services:

- *Name of the organization or the referring individual*
- *Reason for the request*
- *Formulation of the service request made by the client*
- *Date of the service request*

All documents relevant to the service request:

- *Consent forms (for the transmission of information, access to the record, or consent to receive care and services, depending on the case)*
- *Clinical, administrative, legal, or other documents related to the types of services rendered*
- *The forms required for all requests for services or resources*
- *Reports obtained from other professionals or organizations*
- *All relevant correspondence*

Dated and signed notes and reports that reflect professional activities:

For the social worker, these notes and reports[6] include:

- *the psychosocial evaluation*
- *the intervention plan*
- *the individualized service plan (if applicable)*
- *chronological notes*
- *the intervention summary*

For the marriage and family therapist, these notes and reports[7] include:

- *the marital or family evaluation*
- *the treatment plan*
- *chronological notes*
- *the treatment summary*

The client record may contain the following information, if applicable:

- *Information obtained from a third party concerning the client or concerning the third party himself*
- *The consent of the third party to provide the client or other persons with access to this information*

It is strongly recommended that all information provided by a third party, including his identity, be recorded on a sheet or form that is clearly identified for this purpose (e.g.: restrictive notes or tab). If the third party refuses the transmission of the information, this must be clearly indicated on the sheet or form.

If applicable, the written consent of the third party to transmit the information to the client or to another person must be attached to this sheet or form.

The client record must not contain the following information

As a general rule, the professional's work tools should not be stored in the client record. More specifically, these work tools include:

- personal notes, annotations, or hand-written memory aids that are not intended for transmission in their current state;
- tests used to conduct an evaluation or to measure a condition or situation;
- sociograms, genograms, sociospheres, and other tools used during the evaluation or intervention process;
- any other technological means used for reflection or for the development of a professional opinion.

If the professional determines that it is relevant to file any of his work tools in the

or marriage and family therapist is not required to duplicate it.

[6] See Appendix I for a description of the contents of these types of reports.

[7] See Appendix II for a description of the contents of these types of reports.

client's record, he is at liberty to do so. However, once it has been filed in the record, the work tool becomes an integral part of the record, and cannot be removed.

Qualities required in a drafted record

The term report refers to any document that is drafted by a social worker or marriage and family therapist during the course of professional services rendered to a client and then filed in the record.

A report must be:

Concise and relevant:

The social worker or marriage and family therapist must know how to express his observations and opinions in few words, by selecting the essential components of the information related to the client's situation and the context of the services rendered.

These qualities are very important in the current context that surrounds the practice of the two professions, where the rapid circulation of information entails a high risk of breach of confidentiality.

Complete and accurate:

The social worker or marriage and family therapist must ensure that no informational elements that are relevant to the situation are omitted, and must ensure the specific and true nature of all of his statements.

These qualities relate to the accountability of the social worker or the marriage and family therapist.

Objective:

The social worker or marriage and family therapist must record the elements related to the client's situation in a scientific and impartial manner. More specifically, he must clearly distinguish his opinions from the facts reported by the client, quote all sources of information obtained from other people or documents, avoid reporting a medical diagnosis unless the source is quoted, avoid making discriminatory or prejudicial comments, and avoid allusion to any conflict with a colleague, superior, establishment, or any other entity.

This quality also refers to the accountability of the social worker or the marriage and family therapist.

Clear and legible:

All reports must be easy to understand by a lay person, must avoid vague or overly obtuse terms, and must be written in a flowing style rather than a disjointed or telegraphic style. The use of "we" is the current style for written reports, but "I" may also be used. Finally, reports must be free of abbreviations, acronyms, or symbols that are not commonly used and that could lead to confusion.

Handwritten reports must be written in ink, must be carefully drafted in order to prevent any confusion related to interpretation, and must be free of spelling mistakes and erasures. If an error must be corrected, it must be stricken out with a single stroke of the pen so that it is possible to read the text, and the correct text must be written. The use of an eraser or liquid corrector should be avoided.

A typed report must be free of spelling mistakes and printed clearly.

Organized and understandable:

All reports must be logically structured and must accurately reflect the professional's clinical process. Reports must be placed in the client's record in chronological order, and in such a way that it is easy to identify them from among the other documents.

Dated and signed:

Every report must indicate the date when it was completed. There must be a clear distinction between the date when the report was written and the dates when services were rendered.

All handwritten reports and standardized forms must bear the signature of the social worker or the marriage and family therapist.

The paper copy of every typed report must be signed. Electronic signature is authorized for computerized reports (electronically transmitted or included in a computerized record), and is considered to be valid.

Qualities required and rules to follow when drafting chronological notes

Chronological notes are brief notes in the record that are written on a form, a file card, or any other document designed for this purpose. The purpose of chronological notes is to follow the day-to-day progress of the services rendered to the client by the social worker or marriage and family therapist. They are primarily used as memory aids for the professional and as a means for transmitting information to other professionals in order to ensure the continuity of services.

These notes must be:

- *Concise, relevant, precise, and clear;*
- *Legible, free of erasures, dated, and initialled or signed by the social worker or marriage and family therapist.*

It is important to understand that chronological notes have a specific content (see contents of chronological notes, Appendices I and II), and that, in order to satisfy these requirements, it is not sufficient to simply enter the date and the type of activity required.

Chronological notes must be entered between **48 and 72 hours** following the activity itself. However, in urgent cases and in serious, complex, or litigious situations, the notes must be entered within **24 hours** following the activity. In extremely urgent cases, it is also necessary to enter the time of the activity, as indicated in Section 3.06.01.02 of the *Code of ethics of members of the OPTSQ.*

For a variety of reasons, some records may remain nearly inactive for a period of time. However, regardless of the circumstances, the social worker or marriage and family therapist must make at least one entry in the record each year.

In the case of a planned absence (leave, vacation, change of position, etc.), the social worker or marriage and family therapist must ensure that his chronological notes are kept up-to-date.

In the case of an unplanned departure (illness, dismissal, etc,), the social worker or marriage and family therapist must ensure that another professional replaces him and enters the appropriate chronological notes, if possible. Failing this, he must make a note to explain his absence as quickly as possible.

Language used for drafting reports

A social worker or marriage and family therapist is not obligated to use a language other than his own (French or English) when drafting reports. Furthermore, in accordance with the *Act respecting health services and social services,* the establishment must ensure the accessibility of its services, including access to records, for all users, regardless of their origin or language. If applicable, a translation of reports may be necessary in order to ensure that the client understands.

In private practice and at community organizations, the social worker or marriage and family therapist must reach an agreement with the client concerning the language to be used when drafting reports.

Various types of interdisciplinary reports

In the health and social service system, the social worker or marriage and family therapist may be called upon to draft reports or to use forms of an interdisciplinary nature. This type of report or form is authorized, but only under certain conditions:

- *The contents of these reports or forms must reflect the clinical process specific to the profession;*

- *These reports or forms must make it possible to allocate the appropriate level of responsibility and accountability to each professional involved.*

A The joint evaluation or intervention report

This report relates to an evaluation or intervention involving a client that is conducted by two (or more) professionals from different training backgrounds.

This report must contain:

- *factual data, observations, and analyses, which may be drafted jointly;*
- *professional opinions and recommendations, which must be separate and signed by each professional.*

B The individualized service plan

An individualized service plan is required when the user/client must receive health and social services that require the participation of several professionals or more than one establishment over a set period of time.

In the case of an individualized service plan:

- *all of the professionals on the team must participate in the development of the plan;*
- *by consensus, one of the professionals involved must be designated to draft the service plan;*
- *each of the professionals involved is bound by his professional responsibility.*

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The development of an individualized service plan does not absolve the social worker or marriage and family therapist of the need to develop a specific intervention plan with his client.

C Multiclient or multidisciplinary forms

Some of these forms (charts, tools, etc.) entail only the entry of a series of factual data related to the client in order to determine his eligibility to benefit from specific services or resources, among other things. These forms contain information that may be useful when conducting a psychosocial evaluation or a marital or family evaluation, but they do not replace these evaluations, which must be drafted in accordance with the requirements set out by the Order (see Contents of the psychosocial evaluation, Appendix I). However, an abridged evaluation may be drafted while referring to the contents of the form, when appropriate.

Other forms include sections that enable the social worker to enter the elements of his psychosocial evaluation and to formulate his professional opinion and recommendations (e.g.: the forms that are available from the Public Curator). The social worker must sign these sections, and must ensure that there is no confusion with other sections that must be completed by other professionals.

Standard VI:

Standards pertaining to specific fields

In addition to conforming to general standards, a social worker who practices family mediation or who provides expertise in connection with child custody and visitation rights or in connection with protection plans for adult persons or in connection with international adoption must conform to the requirements for record keeping and the drafting of reports that are specific to these fields.

Family mediation

The Guide de normes de pratique en médiation familiale du Comité des organismes accréditeurs en médiation familiale (COAMF), which was adopted by the Bureau of the Order, explains the duties and obligations of family mediators in order to ensure standardization in the practice of family mediation in Québec.

In addition to respecting the requirements of the general standards respecting the keeping of records, social workers who are family mediators must also conform to the following specific requirements:

- *The prevalence of the Professional Code and the Code of ethics of members of the OPTSQ; (Standards of practice statute I - 1)*
- *The principle of the obligation to preserve confidentiality and the exceptions to confidentiality; (Section 2, Paragraph 2.02)*
- *The nature, object, form, and content of the summary of mediation agreements; (Section 6, paragraphs 6.01 and 6.02)*
- *The prevalence of the Regulation respecting the keeping of records and consulting offices by members of the OPTSQ, the rules respecting the keeping of records in mediation, and the storage and destruction of mediation records; (Section 7, paragraphs 7.02, 7.03, and 7.04)*

Expertise in connection with child custody and visitation rights

The main standards that should guide social workers who work in this field, and particularly the standards related to the keeping of records and the drafting of reports are explained in **Les lignes directrices pour l'expertise en matière de garde d'enfants et de droits d'accès** (OPTSQ, February 2006: Chapters IV and V).

Social workers who work in this field must also respect the requirements stipulated in the general standards respecting the keeping of records.

Protective Supervision of Persons of Full Age

The rules concerning the drafting of the reports and their contents, as well as the appropriate conduct concerning the disclosure of information, are explained in detail in the **Guide to the Professional Practice of Social Workers with Respect to Protective Supervision of Persons of Full Age,** (OPTSQ, September 2004):

- *The Psychosocial Assessment: Definition, Process, Ethical Rules (Chapter II)*
- *The Psychosocial Assessment Report: Format, Features, Ethical Rules (Chapter III)*
- *Permission to Disclose Without the Client's Knowledge (Chapter IV)*

Social workers who work in this field must also respect the requirements stipulated in the general standards respecting the keeping of records.

International adoption

The Normes de pratique en adoption internationale de l'OPTSQ (June 2000) explain various rules that apply specifically to this field of practice:

- *Authorization of adoptive parents*
- *Transmission of the recommendations or the report*
- *Drafting the psychosocial evaluation report*
- *Documents that must be kept in the record*

Social workers who work in this field must also respect the requirements stipulated in the general standards respecting the keeping of records.

Standard VII:

Keeping a consulting office

The social worker or marriage and family therapist must practice his profession in an office where the confidentiality of the discussions taking place inside can be maintained, and in such a manner as to protect the identity of the persons inside.

Main definitions associated with the standard

The consulting office

The term “office” is most often used to identify the location where face-to-face and telephone interviews take place between the social worker or the marriage and family therapist and his clients.

The work room

The work room is the place where the social worker or marriage and family therapist drafts his notes and reports, and performs all other administrative tasks.

The waiting room

The waiting room is a room that is set up for clients, which is near to but adequately separated from the office.

Confidentiality of conversations and the identity of persons

Conversation refers to verbal exchanges between people who are in the office, or in other words, the social worker or marriage and family therapist and his clients in the case of face-to-face interviews. Conversation also refers to telephone conversations concerning topics of a confidential nature (other than of a technical nature such as appointment, etc.) between the social worker or marriage and family therapist and his client or about his client.

Recommendations pertaining to professional conduct

At public establishments and at community organizations

The social worker or marriage and family therapist must have an individual soundproof office that can be locked, and the use of a telephone and a filing cabinet. He must display his permit. In certain establishments or organizations, it is possible that the space allocated for the social worker or marriage and family therapist may be in an open area, or may be shared with other professionals. In such cases, the social worker or marriage and family therapist must have an individual and soundproof office (or interview room) in which to conduct face-to-face confidential interviews and telephone interviews. Spaces that are open or that are shared with other professionals are considered to be the professional’s work room. The filing cabinets where the professional’s records are stored may be in the work room, on the condition that nobody has access to it. The permit held by the social worker or marriage and family therapist must be posted near the location where he works, and must be in public view.

The waiting room for users of the establishment or organization must be located at an adequate distance from the consulting office to ensure that the conversations that take place cannot be observed.

The social worker or marriage and family therapist who practices in a public establishment or community organization must notify the Order, in writing, if he is of the opinion that his consulting office does not conform to the requirements listed above. He must first inform his employer that the space that has been allocated does not conform to the Regulation, and must attempt to obtain the necessary corrections.

In private practice

The social worker or marriage and family therapist’s consultation office must be a soundproof individual office that can be locked, and that contains a telephone and a filing cabinet, at the very least, in addition to furniture. The professional must display his permit, and can display only those diplomas that are related to the practice of his profession.

The consulting office must be adequately separated from the work room allocated for an employee (secretary) or any other person (if applicable).

There must be a waiting room designed for clients, located a sufficient distance from the consulting office to prevent anyone from observing the conversations that take place. The waiting room must contain a copy of the *Code of ethics of members of the OPTSQ* and the *Regulation respecting the procedure for conciliation and arbitration of accounts of members of the OPTSQ*, with the address of the Order appearing on it

The social worker or marriage and family therapist must provide a means of notifying clients of an absence that lasts more than five business days (for example an answering machine, receptionist service, etc.), and must notify clients of what to do in case of emergency. It is strongly recommended that the professional clearly advise his clients of his weekly consultation schedule.

The social worker or marriage and family therapist may set up an office inside his home, in which case, the following requirements are added to those listed above:

- *The office must be used only for professional activities, must contain the filing cabinet where the records are kept under key, and must be located at a distance from the professional's living area;*

- *There must be a waiting room designed for clients, located a sufficient distance from the consulting office to prevent anyone from observing the conversations that take place;*

- *If the social worker or marriage and family therapist uses a computer to keep his records, and if other members of the family also use this computer, he must install the necessary security measures to prevent access to the records and documents concerning the clients.*

Interviews conducted outside of consulting offices

The social worker or marriage and family therapist must often conduct interviews outside a consulting office, especially in the home of a client or family, in the room of a client who has been hospitalized or who is in long term care, or in a public venue such as a park, restaurant, etc.

In such a case, the social worker or marriage and family therapist must take all reasonable measures to ensure the confidentiality of verbal discussions. The professional must obtain **the consent of the client** with respect to the inevitable limitations of confidentiality that are associated with such a context.

Appendix I

Contents of reports specific to practicing the profession of social worker

Introduction

The proposed content of the psychosocial assessment report, the intervention plan, and the intervention summary must be flexible and adaptable to the context of the practice, to any type of clientele or field of practice, and to any theoretical framework. The proposed content is designed for an intervention with an individual, but the concept of a client system introduces the notion that it can be adapted to any other form of intervention (marital, family, group, network, etc.).

It is important to point out that the process that leads up to the drafting of the psychosocial assessment report and the intervention plan must take place from a perspective of respect for the client, and on a participative basis, and that the client's opinion concerning his personal situation must be clearly indicated in these reports.

The psychosocial assessment report must be concise, and must contain only those elements that are essential to the situation presented and to the context of the practice.

Definition of the psychosocial assessment

Psychosocial assessment is a planned, structured, continuous activity during which the social worker makes observations and gathers, analyses, and reformulates significant data, both objective and subjective, regarding the situation and psychosocial needs of the individual requiring services.

Psychosocial assessment covers a range of components related to the way in which individuals interact with their environment, as manifested by the individual concerned, and as observed and noted by the social worker, based on various sources. These components are analysed according to reference frameworks specific to the profession, formulated to express a professional opinion, and organized into an intervention plan or intervention strategies.

Psychosocial assessment may be comprehensive to a greater or lesser degree, depending on the context in which the services are provided, the seriousness of the situation, and the legislative framework concerned.

The psychosocial assessment must be the topic of a fairly exhaustive structured report in keeping with the context and nature of the services required.[8]

Contents of the psychosocial assessement report

The psychosocial assessement report must include[9]:

Client identification data

- *Last name and given names*
- *Date of birth*
- *Gender*
- *Ethnic origin / language spoken **
- *Civil status **
- *Job / occupation*
- *Sources of revenue**
- *Housing and means of transportation**
- *Configuration of the primary network (spouse, children, family members, or significant persons)*

Request for services

- *Nature of and reasons for the service requested by the client*

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[8] Taken from *Définition des activités professionnelles des travailleurs sociaux (OPTSQ,mai 2002)*

[9] These contents are primarily based on the following documents :

- Définition des activités professionnelles des travailleurs sociaux, OPTSQ, May 2002
- Keefler, Joan: *Recording Psychosocial Assessments: Problems And Solutions,* Doctorate dissertation (not yet published), August 2005, McGill School of Social Work

* Elements marked with an asterisk (*) are optional, depending on the context of the practice and the problem presented.

- *Referring individual, establishment, or organization*

Information sources

- *List of information sources (third parties, professionals, organizations or establishments, reports, records, etc.)*

Description of the situation and definition of the problem presented

(distinguish between the observations of the social worker and those of the client)

- *The initial manifestations of the situation or problem presented, the trigger elements, the circumstances, the duration, the evolution, and the level of severity of the problem.*

- *The beliefs of the client (or the client system) in connection with the situation or problem, and the client's perception of the impact of the problem*

- *The measures that were previously taken by the client (or the client system) in order to resolve the problem*

- *The priority given to resolving the problem, the client's motivation level, and the obstacles to motivation*

Factors related to the client's personal characteristics

- *The client's behaviour, as observed by the social worker*
- *The client's social functioning (fulfilling various social roles, organization of daily life, affective and intellectual functioning, system of values, and reciprocity with respect to his environment)*
- *The physical and mental state of the client*
- *The client's ability to resolve problems encountered, and the limitations of these abilities*
- *The client's personal background**

Factors related to the environment

Factors that contribute to maintaining the problem, especially:

- Factors related to life cycle
- Cultural factors
- Socio-economic discrimination or other factors

Systemic factors

- *The quality of the reciprocal relationships between the client and those who are closest to him*
- *The existence or non-existence of a broad support network, and the quality of ties with the client*
- *The availability of formal and informal environmental resources, and the constraints related to the existence, nature, or access to these resources*

Risk factors*

The risk factors must be clearly stated in the psychosocial evaluation of individuals who are vulnerable and at high risk for prejudice

Professional opinion

The professional opinion involves formulating an opinion (appraisal) of the client's social functioning and of the situation or problem presented, as a precursor to an intervention:

- *The analysis and summary of observations collected must be based on the facts and the elements presented*

- *The analysis must take into consideration factors related to the personal characteristics of the client, factors related to the environment, systemic factors, and risk factors (if applicable)*

- *Hypotheses that are put forward in order to facilitate the understanding of the situation or the problem must be based on a reference framework that is specific to the profession*

- *The professional opinion may be formulated in accordance with the*

Person-in-Environment (PIE) Classification System

Development of an intervention plan or intervention strategies

The psychosocial assessement must lead to the development of an intervention plan.

In certain contexts, if no social intervention involving psychosocial follow-up is required, intervention strategies must be developed.

The social worker's signature and professional title

The date when the report was drafted

Contents of the intervention plan

The intervention plan must be in writing (on paper or on computerized media), and must be filed in the client's record, regardless of the intervention method used (individual, couple, family, group, community).

The intervention plan must include:

- *The formulation of the problem, as agreed by the social worker and the client (or the client system)*
- *The objectives to be attained or the desired changes, as agreed with the client (or the client-system)*
- *The selected intervention methods*
- *The schedule and terms of the intervention*
- *The indicators selected to evaluate the attainment of objectives*
- *The client's free and enlightened consent*
- *The client's signature (if applicable)*
- *The social worker's signature and professional title*
- *The date when the intervention plan was drafted*

Contents of intervention strategies

In situations where it is not necessary or possible to develop an intervention plan, the social worker must indicate, in writing, the intervention strategies that must be implemented.

More specifically, these intervention strategies involve:

- *Providing a variety of information related to the service requested or the problem identified*
- *Providing referrals to appropriate resources*
- *Implementing various measures for assistance, mutual assistance, protection, representation, or advocacy of rights, as required*

The contents of the individualized service plan:

An individualized service plan is required when the user/client must receive health and social services that require the participation of several professionals or more than one establishment for a determined period of time.

The individualized service plan must include:

- *The needs of the client, as identified by the client and the professionals involved*
- *The objectives to be attained or the desired changes*
- *The names of the workers, organizations, or establishments involved*
- *The anticipated role of each party involved*

- *The duration of the service plan*
- *The development timeframe for each specific intervention plan*
- *The dates of the meetings related to the service plan*
- *The social worker's signature and professional title*
- *The date when the individualized service plan was drafted*

Contents of chronological notes

Chronological notes include any document, form, or file card whose purpose is to follow the day-to-day progress of services rendered to the client by the social worker

The chronological notes must include:

- *The date of the activity*
- *The type of activity (interview, telephone conversation, home visit, case meeting, procedure, referral, mobilization of the social system, etc.)*
- *The names of the persons involved in the activity (client, family member, other professional, initiating resource, organization, etc)*
- *A concise description of the activity (objective of the activity, themes covered, observations of the social worker, opinion of the client)*
- *A brief description of the planned follow-up or the steps to be completed*
- *A brief professional opinion concerning the progress of the situation (if applicable)*
- *The social worker's signature and professional title (at the end of each entry)*

Contents of the intervention summary

The intervention summary must be written (on paper or on computerized media) at the end of every service episode (whether it is scheduled in the intervention plan or not).

The intervention summary must include:

- *A summary of the psychosocial evaluation and the intervention plan*
- *A summary of services rendered*
- *A brief evaluation of the attainment of objectives*
- *The reasons why the services were rendered*
- *The proposed orientation (if applicable)*
- *The social worker's signature and professional title*
- *The date when the intervention summary was drafted*

APPENDIX II

Contents[10] of reports specific to practicing the profession of marriage and family therapist.

[10] This content is included for information purposes, and has been validated by the OPTSQ's Comité de secteur de la thérapie conjugale et familale

CONTENTS OF THE FAMILY EVALUATION

Identification of family members and the family system

- *Last name and given names of each family member*
- *Date of birth and gender of each family member*
- *Ethnic origin / language spoken*
- *Occupation / level of education of each family member*
- *Type of union between the spouses (marriage, civil union, common-law)*
- *Duration of the marital relationship*
- *Type of family (nuclear, single-parent, blended)*
- *Previous union(s) and duration*
- *Socio-economic conditions (type of home, geographic context, income level, etc.)*

Source of referral

- *Identification of the referring individual, professional, or organization*
- *Reason for the referral*

Problem presented

- *Point of view of each family member with respect to the problem presented*
- *Trigger elements*
- *Duration of the problem (recent/chronic)*
- *Repetitive and unproductive behaviour sequences (attempts to resolve problems, homeostatic attempts)*

Family system history

- *Family development history (steps in the life cycle, developmental phases)*
- *Quality of the parent/child bond*
- *Quality of the marital relationship*
- *Contextual stress factors (illness, loss of employment, move, other types of crises, etc.)*
- *Relevant transgenerational factors*

Individual history for each family member (if relevant)

- *Elements of the individual history that have significantly impacted the family's functioning, especially the state of physical or mental health and all associated treatments, such as taking medications.*

Family interaction

- *Structure of the family system (sub-systems, alliances, coalitions, idiosyncratic roles, triangulation, power structure, generational boundaries)*
- *Communication styles*
- *Transgenerational family models*
- *Capacities and resources of the family system*

Interaction with other significant systems

- *Relationships with the extended family, neighbours, friends, workplace, etc. (if applicable)*
- *Relationships with other systems involved with the family, such as a CSSS, YC, school, community organization, etc. (if applicable)*
- *Past or present relationships with other therapeutic resources involving the* family *or one of its members (if applicable).*

Professional opinion (clinical impression)

The professional opinion involves formulating an opinion (appraisal) of the family system by referring to an analysis of family relationships, main areas of difficulty, the capacities and limitations of the family system, its flexibility or rigidity, its openness or lack of openness, its capacity for change, and the motivations of each member of the family.

Treatment plan (see contents on Page 48)

Signature and professional title of the marriage and family therapist

The date when the report was drafted

CONTENTS OF THE MARITAL EVALUATION

Identification of the spouses and the spousal system

- *Last name and given names of each spouse*
- *Date of birth and gender of each spouse*
- *Ethnic origin / language spoken*
- *Occupation / education level of each spouse*
- *Type of union between the spouses (marriage, civil union, common-law)*
- *Duration of the marital relationship*
- *Previous union(s) and duration*
- *Names, ages, and genders of children from each union (if applicable)*
- *Socio-economic conditions (type of home, geographic context, income level, etc.)*

Source of referral

- *Identification of the referring individual, professional, or organization*
- *Reason for the referral*

Problem presented

- *Point of view of each spouse with respect to the problem presented*
- *Trigger elements*
- *Duration of the problem (recent/chronic)*
- *Repetitive and unproductive behaviour sequences (attempts to resolve problems, homeostatic attempts)*

Marital system history

- *Development of the marital relationship from the first meeting to the current development phase*
- *Crises during the course of the life cycle of the couple*
- *Contextual stress factors (illness, loss of employment, move, etc.)*
- *Relevant transgenerational factors*
- *Reciprocal expectations of each spouse, and the current state of these expectations*

Individual and family history of each spouse (if relevant)

- *Elements of the individual history that have significantly impacted the couple's functioning, especially the state of physical or mental health and all associated treatments, such as taking medications.*

Current marital interaction

- *Structure of the marital system (roles, flexibility / rigidity, repetitive models, etc.)*
- *Communication styles*

- *Level and quality of the intimacy*
- *Transgenerational marital model*
- *Capacities and resources of the marital system*

Interaction with other significant systems

- *Relationships with ex-spouses, the extended family, neighbours, friends, workplace, etc. (if applicable)*
- *Relationships with other systems involved with the couple, such as a CSSS, YC, court, community organization, etc. (if applicable)*
- *Past or present relationships with other therapeutic resources involving the couple or one of its members (if applicable).*

Professional opinion (clinical impression)

The professional opinion involves formulating an opinion (appraisal) of the marital system by referring to an analysis of the marital relationship, the main areas of difficulty, the capacities and limitations of the marital system, its flexibility or rigidity, its openness or lack of openness, its capacity for change, and the motivations of each spouse.

Treatment plan (see contents on Page 48)

Signature and professional title of the marriage and family therapist

The date when the report was drafted

CONTENTS OF THE TREATMENT PLAN

- *Identification of therapeutic objectives*
- *Identification of the means for attaining these objectives*
- *Identification of the central elements that may contribute to the dysfunctionality of the family system or the marital system*
- *Frequency and terms of the interviews*
- *Anticipated duration*
- *Consent of each member of the family or couple*
- *Signature and professional title of the marriage and family therapist*
- *Date when the treatment plan was drafted*

CONTENTS OF CHRONOLOGICAL NOTES

Chronological notes include any document, form, or file card whose purpose is to follow the day-to-day progress of services rendered to the client by the marriage and family therapist.

The chronological notes must include:

- *The date of the activity*
- *The type of activity (interview, telephone conversation, home visit, case meeting, procedure, referral, etc.)*
- *The names of the persons involved in the activity (client, family member, other professional, organization, etc)*
- *A concise description of the activity (objective of the activity, themes covered, observations of the marriage and family therapist)*
- *A brief description of the planned follow-up or the steps to be completed*
- *A brief professional opinion concerning the progress of the situation (if applicable)*

- *The marriage and family therapist's signature and professional title*

CONTENTS OF THE TREATMENT SUMMARY

The treatment summary must be written at the end of the marital or family therapy session (whether it is scheduled during the treatment plan or not).

The treatment summary includes:

- *A summary of the marital or family evaluation and the treatment plan*
- *A summary of the evolution of the situation*
- *A brief evaluation of the attainment of objectives*
- *The reason why therapy ended*
- *The proposed recommendations (if applicable)*
- *Signature and professional title of the marriage and family therapist*
- *The date when the summary was drafted*

CONTENTS OF THE FAMILY EVALUATION

Identification of family members and the family system

- *Last name and given names of each family member*
- *Date of birth of each family member*
- *Ethnic origin / language spoken*
- *Occupation of each family member*
- *Marital status of the spouses*
- *Type of family (traditional, single-parent, blended)*
- *Previous union(s) and duration*
- *History of previous consultations*
- *General description of each family member (appearance, behaviour, attitude)*

Source of referral

- *Identification of the referring individual, professional, or organization*
- *Reason for the referral*

Problem presented

- *Point of view of each family member with respect to the problem presented*
- *Recent mitigating factors*
- *Duration of the problem (recent/chronic)*
- *Repetitive and unproductive behaviour sequences (attempts to resolve problems, attempts to maintain the homeostatic balance)*

Family system history

- *History of family development (developmental phases)*
- *Quality of the parent/child bond*
- *Quality of the marital relationship*
- *Evolution of the family system (crises, steps in the life cycle, etc.)*
- *Relevant transgenerational factors*
- *Contextual stress factors (illness, loss of employment, move, etc.)*
- *Relationships with significant systems (work, friends, family members, etc.)*

Individual history of each family member (if relevant)

- *Elements of the individual history that have significantly impacted the family's functioning, especially the state of*

physical or mental health and all associated treatments, such as taking medications.

Family interaction

- *Structure of the family system (sub-systems, alliances, coalitions, idiosyncratic roles, power structure, generational boundaries)*
- *Communication styles (direct, indirect, clear, confused, vague, affective, rational, double binding, etc.)*
- *Transgenerational family patterns*
- *Family system capacities and resources*

Involvement of mezzo systems

- *Other systems involved with the family (CLSC, CSSS, YC, hospital, school, courts, etc.)*
- *Other past or present resources involved with the family or one of its members*

Clinical impression or formulation

Analysis of family relationships, identification of the main zones of difficulty, capacities and limitations of the family system, its flexibility or rigidity, its capacity for change, and the motivations of each member of the family.

Treatment plan (see contents on Page 51)

Signature and professional title of the marriage and family therapist

The date when the report was drafted

CONTENTS OF THE MARITAL EVALUATION

Identification of the spouses and the spousal system

- Last name and given names of each *spouse*
- *Date of birth of each spouse*
- *Ethnic origin / language spoken*
- *Occupation of each spouse*
- *Marital status*
- *Duration of the marital relationship*
- *Previous union(s) and duration*
- *History of previous consultations*
- *Names and ages of children (if applicable)*

Source of referral

- *Identification of the referring individual, professional, or organization*
- *Reason for the referral*

Problem presented

- *Point of view of each spouse with respect to the problem presented*
- *Recent mitigating factors*
- *Duration of the problem (recent/chronic)*
- *Contextual stress factors (illness, loss of employment, move, etc.)*
- *Past attempts to resolve the problem*

Marital system history

- *Development of the marital relationship, from the first meeting to the current development phase*
- *Crises during the course of the life cycle of the couple*
- *Relevant transgenerational factors*

- *Reciprocal expectations of each spouse, and the current state of these expectations*

Individual and family history of each spouse (if relevant)

- *Elements of the individual history that have significantly impacted the couple's functioning, especially the state of physical or mental health and all associated treatments, such as taking medications.*

Current marital interaction

- *Current developmental phase of the marital system*
- *Structure of the conjugal system (roles, flexibility/rigidity, repetitive patterns, etc.)*
- *Communication styles*
- *Transgenerational marital models*

Involvement of mezzo systems

- *Other systems involved with the family (CLSC, CSSS, YC, hospital, courts, etc.)*
- *Other past or present resources involved with the couple or one of its members*

Clinical impression or formulation

Analysis of the marital relationship, the main zones of difficulty, the capacities and limitations of the family system, its flexibility or rigidity, its capacity for change, and the motivations of each spouse.

Treatment plan (see contents on Page 51)

Signature and professional title of the marriage and family therapist

The date when the report was drafted

CONTENTS OF THE TREATMENT PLAN

- *Identification of therapeutic objectives*
- *Identification of the means for attaining these objectives*
- *Identification of the central elements that may contribute to the dysfunctionality of the family system or the marital system*
- *Frequency and terms of the interviews*
- *Anticipated duration*
- *Consent of each member of the family or couple*
- *Signature and professional title of the marriage and family therapist*
- *The date when the treatment plan was drafted*

CONTENTS OF CHRONOLOGICAL NOTES

Chronological notes include any document, form, or file card whose purpose is to follow the day-to-day progress of services rendered to the couple or family by the marriage and family therapist.

The chronological notes must include:

- *The date of the activity*
- *The type of activity (interview, telephone conversation, home visit, case meeting, procedure, referral, etc.)*
- *The names of the persons involved in the activity (family, couple, one member of the couple or family, other professional, organization, etc)*
- *A concise description of the activity (objective of the activity, themes covered, observations of the marriage and family therapist)*

- *A brief description of the planned follow-up or the steps to be completed*
- *A brief professional opinion concerning the progress of the situation (if applicable)*
- *The marriage and family therapist's signature and professional title*

CONTENTS OF THE TREATMENT SUMMARY

The treatment summary must be written at the end of the marital or family therapy session (whether it is scheduled during the treatment plan or not).

The treatment summary includes:

- *A summary of the marital or family evaluation and the treatment plan*
- *A summary of the evolution of the situation*
- *A brief evaluation of the attainment of objectives*
- *The reason why therapy ended*
- *The proposed recommendations (if applicable)*
- *Signature and professional title of the marriage and family therapist*
- *The date when the summary was drafted*

Sources

Main sources for the standards

While not exhaustive, the legal sources for each standard have been reproduced in order to allow the social worker or marriage and family therapist to easily refer to the main sections of the laws and regulations that serve as the basis for each standard.

Sources for Standard I

Code of Ethics of Members of the OPRTQ (c. C-26, r.180)

Sec. 1.01 In this Regulation, unless the context indicates otherwise, the following words and expressions mean:

a) (…)

b) (…)

c) «client»: any person, group, community or organization that benefits from a social worker's services.

d) (…)

Regulation Respecting the Keeping of Records and Consulting Offices by Members of the OPTSQ (c. C-26, r. 189.1)

Sec. 1 A social worker or a marriage and family therapist entered on the roll of the Ordre professionnel des travailleurs sociaux du Québec shall keep a record for each client (…)

Sec. 2 A social worker or a marriage and family therapist may use data processing or any other technique as an additional means of keeping his records, provided he ensures that the confidentiality of all information contained therein is respected.

Sec. 8 Where a social worker or a marriage and family therapist practises in an institution within the meaning of the Act respecting health services and social services (R.S.Q., c. S-5), the record of a beneficiary within the meaning of that Act and its regulations is deemed, for the purposes of this Regulation, to be the record of that social worker if he may enter or have entered therein, in the form of a report or otherwise, the information prescribed by Section 3; in such a case, the social worker is not required to comply with Sections 6 and 7 of this Division.

A social worker or a marriage and family therapist shall sign or initial any entry he makes in a record.

Sec. 9 A social worker or a marriage and family therapist who is in partnership or employed by a partnership or is employed by a natural or legal person may file, where he deems it appropriate, in the records of that partnership or employer all or some of the items or information prescribed by Section 3 regarding the clients to whom he provides services. If the items or information are not filed in the records of the partnership or employer, the social worker shall keep a record for each of his clients.

Organization and Management of Institutions Regulation (D.1320-84, 1984)

Sec. 50 Every institution shall keep an individual record for each beneficiary who obtains services from it, except in cases covered by Sections 45 and 51.

(…)

Nothing in this Regulation shall be interpreted as excluding the use of data processing or any other technique for setting up and keeping files on beneficiaries in an institution.

An Act Respecting the Protection of Personal Information in the Private Sector (R.S.Q., c. P-39.1)

Sec. 4 Any person carrying on an enterprise who may, for a serious and legitimate reason, establish a file on another person must, when establishing the file, enter its object.

The entry is part of the file.

Sources for Standard II

The Québec Charter of Human Rights and Freedoms (R.S.Q., c. C-12)

Sec. 4 Every person has a right to the safeguard of his dignity, honour and reputation.

Sec. 5 Every person has a right to respect for his private life.

Sec. 9 Every person has a right to non-disclosure of confidential information.

No person bound to professional secrecy by law and no priest or other minister of religion may, even in judicial proceedings, disclose confidential information revealed to him by reason of his position or profession, unless he is authorized to do so by the person who confided such information to him or by an express provision of law.

The tribunal must, *ex officio*, ensure that professional secrecy is respected

Civil Code of Québec

Sec. 3 Every person is the holder of personality rights, such as the right to life, the right to the inviolability and integrity of his person, and the right to the respect of his name, reputation and privacy. These rights are inalienable.

Sec. 35 Every person has a right to the respect of his reputation and privacy. No one may invade the privacy of a person without the consent of the person unless authorized by law.

Professional Code (R.S.Q., Chapter C-26)

Sec. 60.4 Every professional must preserve the secrecy of all confidential information that becomes known to him in the practice of his profession.

He may be released from his obligation of professional secrecy only with the authorization of his client or where so ordered by law.

The professional may, in addition, communicate information that is protected by professional secrecy, in order to prevent an act of violence, including a suicide, where he has reasonable cause to believe that there is an imminent danger of death or serious bodily injury to a person or an identifiable group of persons. However, the professional may only communicate the information to a person exposed to the danger or that person's representative, and to the persons who can come to that person's aid. The professional may only communicate such information as is necessary to achieve the purposes for which the information is communicated.

Code of Ethics of Members of the OPTSQ (c. C-26, r.180)

Sec. 3.06.01 A social worker or a marriage and family therapist must respect the secrecy of all confidential information obtained in the practice of his profession. A social worker may be released from professional secrecy only with the authorization of his client or when so ordered by law.

A social worker or a marriage and family therapist must ensure that his client is fully aware of the uses that can be made of the confidential information obtained by the social worker

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Sec. 3.06.01.02 A member who, pursuant to Section 3.06.01.01, communicates information protected by professional secrecy to prevent an act of violence must:

(1) communicate the information immediately;

(2) use the most effective means to communicate the information in the circumstances ; and

(3) enter in the client's record as soon as possible:

(a) the reasons supporting the decision to communicate the information, as well as the name of the person who caused the member to communicate the information and the name of the person or group of persons exposed to a danger ; and

(b) the particulars of the communication, including the date and time and content of the communication, the mode of communication, and the name of the person to whom the information was given.

Sec. 3.06.02 A social worker or a marriage and family therapist must not disclose or forward a psychosocial evaluation report to a third party, except where necessary for the purposes of the Act and where the third party requires it in the performance of his duties.

Sec. 3.06.08 The contents of a client's record kept by a social worker must not be revealed, entrusted or given to a third party, in whole or in part, without the authorization of the client concerned or where the law so requires.

An Act Respecting Access to Documents Held by Public Bodies and the Protection of Personal Information (R.S.Q., c. A-2.1)

Sec. 53 Nominative information is confidential, except in the following cases:

1) where its disclosure is authorized by the person concerned by the information; in the case of a minor, the authorization may also be given by the person having parental authority.

(…)

Sec. 54 In any document, information concerning a natural person which allows the person to be identified is nominative information.

An Act Respecting the Protection of Personal Information in the Private Sector (R.S.Q., c. P-39.1)

Sec. 13 No person may communicate to a third person the personal information contained in a file he holds on another person, or use it for purposes not relevant to the object of the file, unless the person concerned consents thereto or such communication or use is provided for by this.

Sec.14 Consent to the communication or use of personal information must be manifest, free, and enlightened, and must be given for specific purposes. Such consent is

valid only for the length of time needed to achieve the purposes for which it was requested.

Consent given otherwise than in accordance with the first paragraph is without effect.

An Act Respecting Health Services and Social Services (R.S.Q., c. S- 4.2)

Sec. 18 No user is entitled to be informed of the existence or be given communication of information concerning him furnished by a third person which is contained in his record, where knowledge of the existence or the communication thereof would make it possible to identify the third person, unless that person has agreed in writing to the disclosure of the information and of its source to the user.

The first paragraph does not apply where the information was furnished by a health or social services professional or by an employee of an institution in the performance of his duties. For the purposes of this paragraph, trainees, including medical residents, shall be regarded as health or social services professionals.

Sec. 19 The record of a user is confidential and no person may have access to it except with the consent of the user or the person qualified to give consent on his behalf, or by the order of a court or a coroner in the exercise of the functions of office, or if the communication of the information is deemed necessary by an institution in accordance with the provisions of this Act, or for the purposes of the Public Health Act (chapter S-2.2).

Sources for Standard III

Civil Code of Québec

Sections 38 to 40 deal with the right of a client to consult his file, to obtain a copy, and to request corrections, free of charge, and the obligation of the professional to justify his refusal of access.

Professional Code (R.S.Q., Chapter C-26)

Sec. 60.5 Every professional must respect the right of his client to examine documents concerning him in any record established in his respect, and to obtain a copy of such documents.

However, any professional may refuse access to the information contained in such records where their disclosure would be likely to cause serious harm to the client or to a third person.

Code of Ethics of Members of the OPTSQ (c. C-26, r.180)

Sec. 3.07.01 In addition to the particular rules prescribed by law, a social worker or a marriage and family therapist shall promptly follow up, no later than 30 days after its receipt, on any request made by his client whose purpose is:

(1) to examine documents that concern him in any record established in his respect;

(2) to examine documents that concern him in any record established in his respect.

Sec. 3.07.03 A social worker or a marriage and family therapist who, pursuant to the second paragraph of Section 60.5 of the Professional Code, refuses to allow his client access to the information contained in a record established in his respect shall specify to the client, in writing, the reasons for his refusal.

Sec. 3.07.04 In addition to the particular rules prescribed by law, a social worker or a marriage and family therapist shall promptly follow up, no later than 30 days after its receipt, on any request made by his client whose purpose is:

(1) to cause to be corrected any information that is inaccurate, incomplete or ambiguous with regard to the purpose for which it was collected, contained in a document concerning him in any record established in his respect;

(2) to cause to be deleted any information that is outdated or not justified by the object of the record established in his respect;

(3) to file in the record established in his respect the written comments that he prepared.

An Act Respecting Access to Documents Held by Public Bodies and the Protection of Personal Information (R.S.Q., c. A-2.1)

Sections 83, 84, 84.1, and 85 stipulate the right to access records in accordance with the Civil Code.

Sections 86, 86.1, 87, 87.1, 88, and 88.1 stipulate the terms for the refusal of access to records.

Sections 89 and 89.1 stipulate the right to correct records.

An Act Respecting the Protection of Personal Information in the Private Sector (R.S.Q., c. P-39.1)

Sections 29, 30, 31, 32, 33 relate to the right to access records and the associated conditions under the terms of the Civil Code.

Sections 34 and 37 relate to the refusal of access to records and the associated conditions.

Sections 35 and 36 relate to the right to rectification.

An Act Respecting Health Services and Social Services (R.S.Q., c. S-4.2)

Sections 17 and 18 stipulate the right to access records, and the reasons for refusal.

Sections 21, 22, and 23 stipulate who has the right to access records, and the conditions associated with access.

Sources for Standard IV

Regulation Respecting the Keeping of Records and Consulting Offices by Members of the OPTSQ (c. C-26, r. 189.1)

Sec. 5 A social worker or a marriage and family therapist shall keep his records in a room or cabinet that is not readily accessible to the public and that can be locked by key or in another manner.

Sec. 6 A social worker or a marriage and family therapist shall keep each record for at least 5 years from the time he provides the last professional service. At the end of the 5 years, he may dispose of the record, provided he ensures that the confidentiality of the information contained therein is respected.

Regulation Respecting the Cessation of Practice of a Member of the Ordre professionnel des travailleurs sociaux du Québec (c. C-26, r. 179.2)

Sec. 1 This Regulation applies to the disposal of the records, books, registers, apparatus and equipment of a member of the Ordre professionnel des travailleurs sociaux du Québec who ceases to practise.

Notwithstanding the foregoing, this Regulation does not apply to a social worker or a marriage and family therapist who is employed by a natural person, a legal person, a partnership or a government and who ceases to practise.

Sources for Standard V

Code of Ethics of Members of the OPTSQ (c. C-26, r. 180)

Sec. 3.02.01 A social worker or a marriage and family therapist must discharge his professional duties with integrity and objectivity.

Sec. 3.03.01 A social worker or a marriage and family therapist must be available and diligent when practising his profession. If he cannot carry out a client's request within a reasonable time, he must explain the reasons therefor to his client.

Sec. 4.04.01 A social worker or a marriage and family therapist must carefully interpret data gathered during his observations and any expert evaluations carried out as well as data received from his colleagues. In any written or verbal report on social work, he must endeavour to reduce any possibility of such information being misinterpreted or used wrongly by presenting information in a style suited to the persons for whom it is intended.

Regulation Respecting the Keeping of Records and Consulting Offices by Social Workers or a Marriage and Family Therapist (c. C-26, r. 189.1)

Sec. 3 A social worker or a marriage and family therapist shall enter the following information in each record:

(1) the date on which each record was opened;

(2) if the client is a natural person, his family name and given name(s) at birth, sex, date of birth, address and telephone number;

(3) if the client is a firm or a legal person, the firm name, business address, telephone number, and the family name and given name(s) of a representative, his address, telephone number, and title of his position;

(4) a brief description of the reasons for the consultation and a summary of the assessment and the means of intervention the social workers (sic) plans;
(5) a description of the professional services provided and their dates;

(6) a synthesis of the results obtained and any recommendations made to the client;

(7) notes, correspondence and other documents regarding the professional services provided;

(8) report from other professionals obtained with the authorization of the client; and;

(9) the identity of the social worker or the marriage and family therapist on the notes and reports he writes and files in the record.

Sec. 4 A social worker or a marriage and family therapist shall keep the record of each client up to date until he ceases to provide professional services to that client.

Sec. 10 A social worker or a marriage and family therapist covered by Sections 8 and 9 may keep a copy of any entry or report he files in the records of an institution, of the firm or of his employer, provided he ensures that the confidentiality of the information contained therein is respected.

An Act to Establish a Legal Framework for Information Technology (R.S.Q., c. C-1.1)

Sec. 5 The legal value of a document, particularly its capacity to produce legal effects and its admissibility as evidence, is neither increased nor diminished solely because of the medium or technology chosen. A document whose integrity is ensured has the same legal value whether it is a paper document or a document in any other medium, insofar as, in the case of a technology-based document, it otherwise complies with the legal rules applicable to paper documents.

Sec. 34 Where the information contained in a document is declared by law to be confidential, confidentiality must be protected by means appropriate to the mode of transmission, including on a communication network.

Sources for Standard VII

Regulation Respecting the Keeping of Records and Consulting Offices by Social Workers or a Ma(c. C-26, r.189.1)

Sec. 11 A social worker's or a marriage and family therapist's consulting office must be so designed that the person therein cannot be seen and their conversations cannot be heard from outside.

The consulting office does not include the waiting room or any room in which the social worker or the marriage and family therapist or his employees work.

A social worker or a marriage and family therapist who practises in an institution shall hold his consultations in an office complying with this Regulation.

Sec. 12 A social worker or a marriage and family therapist shall provide a waiting room for his clients near his consulting office.

Sec. 13 A social worker or a marriage and family therapist who does not practise on his own account or in partnership shall, after having informed his employer, notify the Order if the design of this consulting office or waiting room does not comply with Sections 11 and 12.

Sec. 14 A social worker or a marriage and family therapist shall display his permit where it can be seen by the public.

Sec. 15 A social worker or a marriage and family therapist may display in his consulting office or waiting room only diplomas relating to the practice of his profession.

Sec. 16 A social worker or a marriage and family therapist shall display a copy of the Code of ethics of members of the OPTSQ (c. C-26, r. 180) in the waiting room. A social worker or a marriage and family therapist who charges fees shall also display a copy of the Regulation respecting the procedure for conciliation and arbitration of accounts of social workers (c. C-26, r. 186).

He shall enter the address of the Order on both Regulations.

Sec. 17 A social worker or a marriage and family therapist or a marriage and family therapist who is absent from his consulting office for more than 5 consecutive working days shall take the necessary measures to inform persons who try to contract him of the length of his absence and the procedure to follow in the event of an emergency.

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