a case in which one therapist told another he had an appointment to see a client "next Friday." As the conversation took place on a Wednesday, the listener assumed the appointment was two days away. The speaker, however, was referring to Friday of the following week. Because the client in question was experiencing a serious crisis, this was a difference of potentially grave consequence.

Although most people would agree that clarity is important in clinical reports, the difficulty lies in recognizing when our own reports are unclear. Because we think we know what we mean when we write something, we assume that what we have written adequately conveys our intention. Thus, we readily overlook passages that may be virtually incomprehensible or, worse, that may appear comprehensible but will be misinterpreted by others.

As suggested earlier, one way to limit misunderstanding is to have someone else read a report before it goes to the intended recipient. If this is not possible, it is often helpful to pretend you know nothing of the case yourself, then read the report out loud. Reading aloud brings out aspects of writing that we do not recognize when we read silently to ourselves. If time permits, another extremely valuable technique is to set a report aside for several days and then read it again with an open mind. Along with helping to identify writing problems, this also allows one to think more about the case before sending the report.

I cannot overemphasize how important clarity is to your writing. Clinicians simply must learn to be extremely careful about their words. You must know and say precisely what you mean. It is not enough to defend with "C'mon, you know what I meant." That may work in everyday discourse, but it is unacceptable in professional work. If the reader does not know exactly what is meant, the responsibility falls on the writer, not the reader. Say what you mean and say it clearly. I feel so strongly about this that I have on occasion told students bluntly, "If you do not want to learn to use words carefully and accurately, you should probably consider another profession."

KNOW YOUR AUDIENCE

The final recommendation about writing is to know your audience. Some instructors and articles about clinical writing dictate specific and fixed rules for the style and content to be included in clinical reports. I prefer an approach that offers suggestions but at the same time encourages you to choose and adapt your style and content with an awareness of your audience. This principle has also been highlighted by Brenner (2003), who speaks of "consumer-focused" psychological assessment and the importance of making our writing relevant and useful to the people who will be reading it.

Fischer (1994) says repeatedly in her book: "Reports are for readers, not for the author" (p. 115). Tallent stresses this principle as well and cites a report by Hartlage and Merck (1971) that showed that the utility of reports is primarily weakened by, as Tallent (1997) describes it, a "profound . . . lack of reflection by report writers on what might be useful to report to readers, a simple failure to use common sense" (p. 20). Hartlage and Merck (1971) observed, "Reports can be made more relevant to their prospective users merely by having the psychologists familiarize themselves with the uses to which their reports are to be applied" (p. 460).

A report prepared for a fellow professional in your discipline may differ from a report prepared for an attorney, family members, or others with different backgrounds and needs. Similarly, if you believe certain aspects of a client are being overlooked by others, you may want to emphasize those in your report. The most important thing is for you to write with conscious awareness of how your style and content meet your clinical and professional purpose.

EXERCISE

As a way of enhancing your awareness of different groups to which your reports might be targeted, read the following list and write some of the concerns that you might keep in mind if preparing a report for each of these people. You might consider such factors as the readers' level of training or knowledge, how much time they have, and the style of reports they are accustomed to reading. How do these and other factors differ for each of the groups listed?

- The client
- Family members of the client
- Insurance companies
- Clinical psychologists
- Counselors
- Social workers
- Psychiatrists
- Nonpsychiatrist MDs
- Schoolteachers
- Students
- Attorneys
- Judges
- Professional journals
- Newspapers
- Others for whom you might write

Reviewing the list should enhance your awareness of general factors to consider in writing, but you must also remember that, regardless of their profession or role, different individuals will have different preferences and needs. One schoolteacher may be well versed in diagnostic categories, but another may know nothing at all about them. One psychiatrist may prefer reports that are as brief as possible and that convey "just the facts." Another may appreciate more detailed reports that convey a sense of the client as a person.

If you know for whom you will be writing before you write a report, it is sometimes a good idea to contact the person and ask about his or her preferences for style and content and any specific requirement for the report. After you write a report, you

can follow up by asking the recipient for feedback. Your role as an intern gives you a perfect opportunity to ask for such information, and many people will be glad to offer their suggestions.

THE FUNCTION AND MAINTENANCE OF RECORDS

One of the responsibilities of all health care professions is to maintain accurate records regarding the diagnosis and treatment patients receive. By understanding the function of clinical records and developing a systematic approach to their use and maintenance, you can make record keeping a recognized and accepted element of your clinical training and later practice (Casper, 1987; Kagle, 1993; Van Vort & Mattson, 1989).

Van Vort and Mattson (1989) emphasized that records serve multiple functions. They contribute to the quality of a client's current and future care, satisfy agency requirements, document care for the purpose of third-party reimbursement (i.e., payment for care by insurance companies), and protect against legal actions. The same functions were identified by Reamer (2005) and are in the specified organizational guidelines and codes of ethics of all the major professional associations. Casper (1987) noted that medical hospitals and other health care institutions must maintain adequate records to receive approval from auditing agencies such as the Joint Comission on Accreditation of Hosptials and government agencies in charge of Medicare and Medicaid.

In a brief but highly informative review, Soisson, VandeCreek, and Knapp (1987) considered the legal importance of records in our litigious society. Based on their review of existing case law, they emphasized that well-kept records can reduce the risk of liability, whereas the lack of good records may in itself be used as evidence that care was substandard. This point was reiterated by Reamer (2005), Harris (1995), and by Bennett, Bryant, VandenBos, and Greenwood (1990), who stated: "In hospital practice it is often said, 'If it isn't written down, it didn't happen' " (p. 77).

For these reasons, an essential part of your responsibility as a professional will be to maintain quality records. To do that, you should understand what goes into records, what stays out, and some of the models for organizing and writing progress notes. Examples of forms for documentation and record keeping can be found in Wiger's (1999) clinical documentation sourcebook.

WHAT GOES INTO RECORDS

EXERCISE

Before reading the following discussion, give some thought to all the information you would like to know about a client. Organize this into categories and create a simple form to use for an initial intake interview. When you have generated your list of key information, compare your ideas with peers to see what their approach is and what issues they have identified that you have overlooked.

When I refer to clinical records in this text, I am speaking of the totality of information pertinent to the client's treatment. The general rule for determining what to put in records is: If something is important, document it and keep a record, but think carefully about what you say and how you say it. Good records should include all present and previous relevant information about a client's history and treatment, current diagnosis, correspondence, releases of information, documentation of consultation, billing information, informed-consent forms, and any other pertinent information. At the same time, however, psychotherapy notes should probably not go in general records because, as mentioned in Chapter 3, HIPAA guidelines protect the confidentiality of psychotherapy notes, but only if those notes are kept separately from the rest of the client's health care records. More will be said about psychotherapy notes later in this chapter.

Different institutions and agencies have different record-keeping technologies. As discussed in Chapter 3, more and more settings are shifting to computerized electronic health or medical records systems (EHRs and EMRs), and these will eventually become the norm. (Bower, 2005; RAND, 2005; Steinfeld et al., 2006). If you have not yet read Chapter 3, now would be a good time to do so, because you will undoubtedly encounter electronic record systems at some point, either in your internship or your later practice. As such, you need to have an understanding of the ethical and legal issues associated with such systems.

In more traditional settings that have yet to adopt an electronic system, typical physical materials involve either manila or metal folders subdivided into sections containing certain types of information. For convenience, subsections are often color-coded and flagged with tabs identifying the contents. To ensure compliance with record-keeping guidelines, most institutions have some form of periodic record review that assesses the content, organization, clarity, and security of records. This has always been good practice but is now mandated under the HIPAA rules.

Whether one is using a traditional paper-based system or an EMR model, any approach is only as effective as the people who use (or in some cases fail to use) it. Kagle (1993), Casper (1987), and Van Vort and Mattson (1989) all described systems for encouraging improved record keeping and greater compliance with agency guidelines. These include simplifying records, reducing redundancy, utilizing established forms to collect information, and using technologies such as computers and dictation systems. Some agencies have also hired time-management consultants to help assess how much time is actually going toward record keeping and how to improve efficiency. With the advent of HIPAA guidelines,

most agencies will have procedures and personnel in place specifically to ensure HIPAA compliance regarding electronic records, informed consent, communication of patient information, security and other issues covered under HIPAA.

Perhaps the most concise and informative discussion of how to organize and what to include in records was provided by Piazza and Baruth (1990), who described six categories of material that should go into records. In discussing the utility of their system, Piazza and Baruth noted that it has been used successfully in many treatment settings and that records kept according to the system have consistently passed state and national standards. After reviewing the general categories these authors identified, we will look more closely at progress notes and psychotherapy notes.

Within each of the major categories of record contents, Piazza and Baruth (1990) listed more specific information that should be included. Under the category "Identifying or Intake Information," they suggested that basic personal data such as name, address, home and work phones, date of birth, sex, family members' names, next of kin, and employment status should be recorded. Also indicated here should be information about the date of initial contact, the reason for referral, and the names of other professionals (e.g., physicians, other counselors) who are seeing or have seen the client. Most agencies use standard forms to gather the information in this category. In some instances, the information is completed by the client; in other settings intake specialists or the therapists themselves discuss the information with clients and record the data as the discussion proceeds. Interactive computer programs have also become available to allow clients to enter this information themselves.

Taking this type of information is a straightforward process with most clients, but in some cases clients may not want to be contacted at their home address. For example, I have worked with abused spouses who did not want their partner to know they were seeing a therapist. In these circumstances, you need to flag the record in some way to indicate precisely where and how a client should be contacted and billed. This must be done in such a way that the therapist, secretaries, records departments, or other clerical personnel cannot inadvertently call the client's home to schedule an appointment or send billing information that would reveal the client is seeing a therapist.

The second category described by Piazza and Baruth (1990) contains what they identify as "Assessment Information." This information is typically collected at the outset of treatment for the purpose of developing treatment plans. In some approaches to records, this information might also be included in the initial intake forms alluded to earlier. Within the heading of assessment information, five "domains" are considered by Piazza and Baruth to be essential. The first domain, "Psychological Assessment," addresses the client's "motivation for treatment," emotional status and functioning, cognitive capacity, and history of previous difficulties or treatment. "Social and Family Assessment," the second domain, encompasses the client's early family and developmental history, including parents, siblings, family dynamics, and any family history of illness. It also includes the client's current family and social status and functioning.

Piazza and Baruth (1990) emphasized the importance of not only considering information about dysfunctional aspects of the client's life but also attending to the client's strengths and resources. Such information is particularly relevant to the third domain, "Vocational/Educational Assessment." Along with information about employment and academic history, this domain takes in avocational interests, as well as leisure and recreational activities. In considering a client's background, it is important to look beyond titles of jobs or education to consider specific skills and accomplishments. Thus, if a woman seeking employment identifies herself as a "homemaker," the counselor should explore the skills, such as money management, planning, organization, and child raising that may have gone into that role. Clients may tend to overlook such skills, but identifying them as resources can be immensely valuable in mobilizing the client's strengths as part of the therapy process.

The fourth and fifth domains are, respectively, "Drug and Alcohol Use" and "Health Assessment." As these titles are self-explanatory, they will not be discussed further here except to emphasize that many helping professionals pay too little attention to the role of physical factors. Physical illness and lifestyle characteristics such as smoking, drinking, sleep patterns, and caffeine use may all be significant causes of, or contributors to, clients' difficulties. I advise interns wherever possible to obtain the requisite information releases and establish close contacts with clients' physicians. I also suggest, as do Piazza and Baruth (1990), that clients who have not had complete physicals within the past year be encouraged to see a physician for a thorough checkup. A number of concerns that present with psychological symptoms may be caused by or related to underlying physical illness. To assess this possibility, you may wish to contact the physician before the client's visit and discuss the physician's findings after the client has been seen. Finally, remember, as discussed in Chapter 3, federal guidelines require that information about treatment for drug or alcohol abuse must be provided special confidentiality protections including special treatment in any record system accessible to others.

In gathering and considering any of the previous data, keep in mind that some patients may be unreliable sources of information. Therefore, with appropriate consent, it is advisable to obtain corroborating information from family or friends. Meeting with family members or friends at intake is virtually an essential for clients who, because of their presenting concerns (e.g., mental disorders, brain injury, certain personality disorders), may not be able or motivated to provide accurate data about themselves. Before making such contacts or conducting such meetings, however, you must be sure to have the client's specific written authorization.

Along with the information described thus far, as part of an initial assessment I strongly recommend that if a client has been or is being seen by other treatment providers or related professionals,

you should, with the client's authorization and signed release of information, seek copies of those records. If a client is reluctant to allow you access to such records, that may serve as a red flag for making further inquiries about the client's reasons. You should also be cautious in deciding whether to accept the client for treatment if you cannot obtain past records. From the perspective of managing liability risks, it is not advisable to treat clients without access to information about previous treatment. The reason is that such information can have a significant impact on how you understand the client's present situation and how you provide treatment yourself. If you have not made an effort to gather information about past or other ongoing treatment, and if you do not document that attempt and information in your own records, you could face added problems if legal concerns arise.

With information from the first two categories, clinicians are able to formulate treatment plans. "Treatment Plans" constitute the third category in the record model of Piazza and Baruth (1990). They suggest that the client and the therapist should agree to and sign each treatment plan. At a minimum, the plan should include a statement of the problem, the goal of treatment described in behavioral terms, and the steps that will be taken to achieve the goal. As treatment proceeds, the client and therapist should periodically review the treatment plan to assess progress and adjust the approach or goals as needed.

Managed care and other changes in health care are placing increasing demands on professionals in the mental health field to demonstrate the rationale for, and efficacy of, the work we do with clients (Braun & Cox, 2005; Rupert & Baird, 2004) In some cases, if you have not formulated a sound treatment plan from the outset, and if you do not document through progress notes that your subsequent work with the client has followed your plan, you, the agency you work for, or the client may be denied compensation from the insurer. Thus, along with contributing to the quality of patient care, well-formulated and clearly documented treatment plans can also contribute to your financial well-being and that of your clients.

Ongoing "Case Notes" form the fifth category in Piazza and Baruth's (1990) model. Piazza and Baruth suggested that these notes should include the goals for each session, indications of whether the goals were met, behavioral observations and clinical impressions, and a plan for the next sessions. In light of HIPAA protections for psychotherapy notes that are stored separately, I recommend that therapists simply include in the general record the time and date of the session, whether or not the patient appeared, a brief and very general statement of what occurred in the session, and any relevant follow-up. Notes of the actual content of the session and the therapist's impressions should be kept separately from the general record. At the conclusion of treatment with a client, the therapist should also write a brief synopsis of the case at termination and include it in a termination summary that reviews the origin, course, and result of treatment. If the client will be referred to another professional, the termination summary should include mention of this or of other aftercare plans.

The sixth and final category within records is labeled simply "Other Data." Include here such things as authorization for treatment, releases of information, copies of test results, and communications from other professionals. If you consult with other professionals about a case, make records of the consultation and include them here or in your case notes. Because this portion of records can become quite crowded with miscellaneous material, you may find it useful to organize the material with tabbed inserts.

WHAT STAYS OUT OF RECORDS

PROTECTING CLIENTS

Like all simple rules, there are caveats to the rule of documenting everything that is important. In the case of clinical records, the caveat arises because your case records are not strictly confidential. This reality is clearly recognized in the APA (1993) Record Keeping Guidelines, which state:

> These guidelines assume that no record is free from disclosure all of the time, regardless of the wishes of the client or the psychologist. (p. 985)

Each of the ethical codes also explicitly mentions that information, including information in clnical records, may under certain circumstances be required to be disclosed. Recognizing the possibility that records may be disclosed does not mean that you can afford to be careless or that it is not your responsibility to protect records from disclosure wherever legally required and permitted. It does mean that when you keep any sort of record about clients or their treatment, you should keep in mind the possibility that others might have access to the record.

Institutional settings are an example of where confidentiality of records may be limited. If your treatment records are, or will become part of, a larger record to which other staff have access, it is obvious that your records can be seen by others. Under these circumstances, it would not be in the client's best interests to reveal in such accessible records information that was shared with you in confidence or that might be harmful to the client. This is another reason it is a good idea to keep psychotherapy notes separately.

Another possibility that you should be aware of concerns computerized case notes and outcome data. Wedding, Topolski, and McGaha (1995) provided a comprehensive review of the issues associated with computerized notes, particularly within the context of managed care and cost-containment efforts. Jeffords (1999) reported that the National Research Council found the path of the typical medical record has changed with the proliferation of technology. Twenty-five years ago records were held and used by a personal physician. Today, records may be handled by numerous individuals in more than 17 different organizations. Recognition of this reality is part of the reason the

HIPAA guidelines about electronic data storage, communication, and security are so explicit and, along with specifying what information can and cannot be exchanged, include measures such as passwords and encryption to protect against hackers and other intrusions.

PROTECTING YOURSELF

Just as it is important to protect clients from the possibility that records may be viewed by others, it is also important to protect yourself. No clear-cut rules exist in this area, but interns and clinicians would do well to ask themselves how what they put in records might later sound in a court proceeding. Gutheil (1980) went so far as to suggest that trainees

> deliberately hallucinate upon their right shoulder the image of a hostile prosecuting attorney who might preside at their trial, and that to this visual hallucination they append the auditory impression of the voice most suited to it. (p. 481)

Gutheil (1980) continued, saying:

> Having achieved this goal-directed transient psychotic state, the trainee should then mentally test out in that context the sound of what he or she is about to write. (p. 481)

This does not mean that you should be frightened about everything you write or that you should expect a lawsuit around every corner. At the same time, however, being aware that your records and notes can be exposed and analyzed in litigation serves as a helpful reminder and incentive to keep the quality of your treatment and documentation at the highest levels possible.

Keep in mind, too, that under HIPAA guidelines, clients have access to their own records. Again, psychotherapy notes are protected if kept separately, but in the portion of the record that is accessible to clients upon request, it is advisable to avoid recording your own emotional reactions or opinions about clients if such reactions could be clinically harmful or litigiously consequential when read by a client.

From a liability risk-management perspective, two things to avoid in records are "raising ghosts" and taking blame. By raising ghosts, I mean recording unfounded or unnecessary speculation in your notes. For example, if a client seems a bit down during a session but there is no reason from the client's history, statements, or actions to suspect suicide potential, it would be unwise for a clinician to record "Client was down today but I do not think suicide potential is high." If you mention suicide, you must also assess the potential carefully and document that you did so. If suicide risk is not elevated above normal, do not mention it at all. The same would apply to issues relating to dangerousness to others. Do not simply speculate about something so serious in your notes unless you followed up on that speculation during your session.

A second thing to avoid in records is taking blame. Do not write in your notes that you made a mistake in treatment. This might feel honest and cathartic, but it could get you into trouble later. If you are tempted to make such an entry, ask yourself what good it serves to write in your own notes that you made an error. You know it yourself, and that is sufficient. Remember the advice your auto insurance company gives you if you are in an accident. If something unfortunate happens and you have to defend an action in court, allow your attorney to advise you but do not put confessions in your records beforehand.

Finally, never falsify records. If your records are demanded for a legal proceeding, you will be asked under oath if your records represent a true and accurate description of your treatment or have been altered in any way since they were originally written. If you alter records and do not so indicate, you may be guilty of perjury. It is far better to be careful in your treatment and in your records to begin with and then to be scrupulously honest if you are ever called to court. If at some point in your work with a client you realize that a previous record was deficient in some way, at the time you notice the deficiency you can make a note that you discovered something that needed to be added or changed in an earlier note. This does not mean you go back and actually change the note. It means you make a separate and later note that indicates the need to adjust, clarify, or correct the earlier note.

For example, suppose that two days after you wrote an entry you are reviewing the notes and reflecting on the earlier session. As you think about the session, you realize that something should be added. At that moment, write the present date and time, then indicate the change or correction. This process demonstrates the value of periodic note review because you must catch such omissions before any trouble develops and legal implications arise. Corrections made after legal action or after an unfortunate event are not likely to carry as much weight in court because they tend to be seen as self-serving.

PROGRESS NOTES AND PSYCHOTHERAPY NOTES

EXERCISE

If you are working in a clinical setting, find out if you can obtain permission to review some of the patient records. Then read the progress notes kept in the records and ask yourself the following questions: Can I detect differences in style or content for different staff members? What notes stand out as useful? What notes are not useful? What matters of style and information account for this difference?

STANDARD FORMATS

In an effort to standardize treatment notes, many agencies have developed or adopted specific guidelines for what should go where in notes. This is very important in medical settings or