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Purposes of Clinical Records

From the very first session, practitioners engage in the process of relationship building. While gathering information from their patients, they seek to develop rapport by listening empathically. They strive to understand the complexities of their patients’ diverse contexts. They work to collaboratively construct a hopeful therapeutic relationship, now recognized by researchers to be the key factor in successful outcomes, more significant than type of treatment (Allen, Fonagy, & Bateman, 2008; Gabbard, 2010; Horvath, 2005). Effective record keeping promotes a positive therapeutic alliance and improves treatment outcomes when clinicians’ work with their patients reflects respect, concern, and collaboration.

Competent record keeping is not just a boring burden thrust upon practitioners by external forces, and it is not simply good risk management. It becomes a dynamic aide in developing a framework for supporting the therapeutic alliance from the outset and through various stages of our collaborative clinical work with patients.

All mental health organizations have codes of ethics that highlight the paramount importance of protecting patient confidentiality and maintaining the highest professional standards to protect patient welfare. Sadly, few mental health professional organizations or state laws define and describe the characteristics involved in competent clinical record keeping. There is little written about the therapeutic process of record keeping. This leaves practitioners to use what little they can learn in graduate schools or internships, or to devise their own policies and methods in a virtual vacuum. However, several recent developments are challenging graduate schools, clinical supervisors, and therapists to focus on documentation. First, clinical research that highlights the central importance of the therapeutic relationship challenges therapists to document their care and clinical decision-making processes and to use record keeping as a collaborative treatment tool. Second, the Health Insurance Portability and Accountability Act (HIPAA) requires practitioners who generate patient-identifiable health care information electronically to develop written information that explains to their patients how they use treatment records, how they protect the privacy of those records, and how they may have access to their records (U.S. Department of Health and Human Services, 2001c). Third, increasing numbers of malpractice
cases and complaints to state licensure boards are forcing clinicians and their supervisors to practice more careful and thoughtful documentation. Fourth, higher rates of litigation in our society mean that more practitioners are receiving subpoenas for patients’ records and are struggling to find ways to respond and still protect patients’ needs for privacy. Finally, more therapists today are anticipating retirement or leaving their practices for other reasons and must make advance plans for their patients’ records.

The need for knowledge and methods in record keeping has never been more urgent. The goal of this second edition is to enhance behavioral and mental health professionals’ ability to write, maintain, and use records in order to help develop and preserve the therapeutic alliance, promote healing, and protect patients’ privacy.

Systematic clinical records are essential for the following reasons:

1. Records facilitate communication between therapists and clients. Inviting patients to discuss diagnostic impressions and treatment options and to contribute their own perspectives, including on what is helpful and not helpful in their treatment, can help create an atmosphere of safety and mutual respect. Records help patients understand their problems, make meaningful decisions about their treatment, develop insight, and become partners in their own healing. Records help to create trust in professional relationships. The process of informing patients about why and how practitioners maintain and protect their records demonstrates commitment to patient welfare.

2. Records form the basis of sound diagnoses and appropriate treatment plans. Reviewing records over time allows therapists to identify significant patterns and modify diagnostic hypotheses and treatment plans. Keeping records also allows practitioners access to more dates and information than they can reliably maintain in memory.

3. Records provide for continuity of care. Clear, concise records allow other practitioners to follow and understand what has occurred in therapy and the rationale for interventions. New practitioners can pick up where previous therapists left off or explain to patients why they are recommending a different course of action. Without good records, patients’ need for continuity of care suffers.

4. Records are necessary for clinical supervision. Records are indispensable tools for evaluating and remediating knowledge and skills. Developing supervision contracts promotes systematic attention to supervisees’ learning needs and provides informed consent to supervision. Reviewing records allows supervisors to see how well supervisees or trainees are developing clinical hypotheses and treatment plans and to help them document their findings and interventions appropriately.
Through discussions of records, trainees gain greater objectivity, which ensures better treatment for patients.

5. Records satisfy the requirements of contractual obligations with third-party payers. In many instances, mental health services cannot be reimbursed without documentation of diagnoses, treatment plans, and client progress. A clear record of events also facilitates writing appropriate reports about patients.

6. Records are practitioners’ and clinical supervisors’ best (and sometimes only) protection against allegations of unethical and harmful treatment. We live in a highly litigious society. Detailed records are the best protection against specious claims. Contemporaneous documentation of events, agreements, and professional decisions can demonstrate the bases for clinical and ethical decision making and provide proof of good-faith efforts.

For these reasons and more, it is essential that practitioners, while developing the therapeutic alliance, become proactive about keeping coherent, concise, accurate, and timely patient records in collaboration with their patients and assiduously protect the confidentiality of those records.