Today’s sport psychologists focus on establishing rapport with their clients (e.g., athletes, coaches, whole teams), and may not document their work as much as would be required of licensed clinical psychologists. They work long hours, have limited time for paperwork, balance competing demands for increased accountability against their clients’ needs for privacy, and, in difficult economic times, may experience job uncertainty and decreased income for their services. Where is the time to document each professional encounter? Why not just rely on memory or scribbled notes? Are records really necessary anyway? If so, what should go in them?

As we struggle to make our way, it helps to realize we are not alone. Many psychologists express uncertainty about what constitutes good record keeping practices. (Luepker, 2003; Scaife & Pomerantz, 1999) They have not received training or support in how to manage these essential professional tasks, much less how to use records as therapeutic tools. Further, even though professional organizations highlight the importance of maintaining high standards to protect client welfare and professional ethics codes and regulatory boards specifically require records (e.g., American Psychological Association [APA], 2007; Australian Psychological Society [APS], 2004, 2007; British Psychological Society [BPS], 2008), none adequately define nor describe the characteristics of competent record keeping. Only recently have academic programs begun recognizing the urgent need to include knowledge about record keeping in psychological counseling curricula. Although some psychologists are lucky enough to learn about documentation during their clinical or counseling practice and internships, most are left to muddle through. To help fill this gap, in this Chapter I share tips on key issues in record keeping including: purposes, what to include, how to say it, how to keep it simple, and how to plan for records in the event of interruptions or closure of practice.

**Purposes**

Even when our clients request that we keep no records, if we are to be ethical, we do not have a choice (APA, 2007; APS, 2004; BPS, 2008). Reasons systematic clinical records are essential include, but are not limited to, the following:

- to facilitate communication between psychologist and clients;
to form the basis of sound assessment and appropriate treatment plans;
■ to provide continuity of care;
■ to facilitate supervision;
■ to satisfy requirements of regulatory boards and ethical codes of conduct (e.g., APA, APS, BPS);
■ to satisfy contractual obligations with third-party payers;
■ to facilitate writing reports (e.g., formal assessments, legal documents);
■ to protect clients, practitioners, supervisors, and employers.

General characteristics

The majority of records I have reviewed when providing consultations to attorneys in malpractice cases, and to anxious practitioners regarding complaints against them, were, unfortunately, nonexistent, sparse, illegible, or incoherent. Sadly, this state of affairs meant that reputations and careers of competent practitioners and their supervisors (and their employers) were needlessly at risk due to inadequate documentation of their professional services.

In one case, a grief-stricken mother sued her son’s psychologist, alleging that sub-standard counseling care caused his suicide. Unfortunately, the practitioner’s progress notes did not show what her professional interventions were and what transpired in each session. Although her writing was legible, it was limited to scattered words, apparently jotted down during sessions. No quotation marks or pronouns helped to clarify who said or did what (e.g., “he stated ...,” “I asked him ...”).

Fortunately, however, the record included copies of the psychologist’s letters to other professionals, which revealed the competent care she provided. Her letters clearly summarized the young man’s problems, his difficulties functioning, his lack of progress, and the need for further professional evaluation and collateral services. Her correspondence showed her compassionate, conscientious, and professional efforts to help this young man, whose personal daily journals depicted his chronic despair and wish to die. Although it was a tragedy the young man killed himself, and even though the counseling professional’s records of sessions did not convey her quality work, the letters provided sufficient documentation to indicate that the treatment she provided met the standard of care in her community.

In addition to being practitioners’ best protection against specious claims, competent records also help to protect the professional relationships, the building blocks for success. Whether clients choose to exercise their rights to access their records or whether psychologists choose to share their records as part of the therapeutic process (e.g., sharing their documentation with clients when crafting evaluations and plans with their clients, monitoring progress, terminating treatment), records can become a dynamic therapeutic aid (Luepker, 2003).

When records convey professional work in humane, legible, and plain language, they can become invaluable therapeutic tools to help clients see themselves within the context of their life experiences, the work they have done in therapy, their progress or lack thereof, and our genuine concerns for their well-being. When records contain inaccurate or pejorative language, records can hurt clients. For example, a professional woman confided she felt devastated when she read in her own record that her counseling practitioner described her as “ugly.” Had the professional used more neutral, less value-laden language, this woman could have been spared unnecessary emotional pain.
For practitioners to protect themselves and their clients, and to be able to use records to enhance the professional relationship and work with their clients, here are some essential characteristics of adequate records:

- legible (to self and others);
- germane (only information relevant to assessment/diagnosis, intervention/treatment, progress or lack thereof, and outcomes);
- reliable (e.g., cite specific source of information, document all risk situations and preventive action taken, take care in deciding when and how to document sensitive information, avoid conjectures and prejudicial comments);
- logical (intervention/treatment plans follow logically from assessment/diagnosis; progress notes show interventions geared to problems);
- chronological (organized by date);
- concise (ongoing progress notes can often be limited to 4–5 sentences).

**General contents**

Our goal is simple: to make what we do and why we do it clear to ourselves, to our clients, and to any other party who may have a legitimate need to see the records. It helps to ask ourselves questions such as the following: Is it clear from reading the record who the client is (e.g., athlete, coach, team)? How did we arrive at the intervention plan? Have we discussed options? Were we careful (e.g., informed clients whom they may call in case of emergency during our absences)? Did we record specific action we took to protect an identifiable victim of potential violence, or suicide, or other harm? Did we provide the rationale for our intervention and what progress the client made or didn’t make? Did we explain why and how the client ended the work with us? If we were to die or become unexpectedly incapacitated tomorrow, could another practitioner look at the record and be able to find enough information about the client and our work to pick up where we left off? The framework for holding this necessary information includes the following:

- Standard Face Sheet (if individual – name and date of birth, address, home and work numbers, including emergency contacts, legal guardianship information, if appropriate; if team – name and type of team, and so forth);
- client’s name on each page;
- date, psychologist’s signature, and degree on each entry;
- billing record with matching dates, type of sessions (e.g., individual or team, length of sessions);
- evaluation, assessment, treatment plan (progress notes);
- appropriate, signed consent forms (including policies for confidentiality and exceptions);
- preventive action taken, including referrals related to life-threatening risks and/or client’s inability to conduct daily activities of living;
- documentation of appropriate coordination and continuity of care between providers serving the client;
- record of other “nonroutine” disclosures (date/time of disclosure, purpose, information provided and to whom [name, organization, telephone, or fax response of receiving party]);
Assessment or evaluation

Summarizing the assessment of a client need not be difficult. Styles of record keeping can vary. Although check lists are valuable in helping us to systematically gather essential information that we might forget in an interview, the narrative form is far easier to understand. Reserving an hour immediately after an initial assessment to write while the material is still fresh in our memories saves trouble later. Using an outline that includes the following makes an assessment summary relatively simple to compose:

- brief statement that describes client (e.g., gender, age, educational status, socio-economic status, marital status, children, with whom living, type of employment or course of study, reasons for referral, source of referral, diversity / multicultural factors);
- presenting problems;
- history of problems (include onset of problems, specific description of context of onset, who has done what to whom, what / how client has tried to solve problems, what’s worked, what hasn’t worked);
- significant bio-psychosocial and cultural history (family, work, school, relationships, religiosity, social activities);
- significant history of medical problems;
- interview observations, including description of client’s appearance and mental status (e.g., affect, speech, mood, thought content, judgment, insight, memory, impulse control, attention/concentration);
- assessment consistent with data; document any dual or multiple diagnoses, assessments ruled out;
- documentation of any referrals made or any received (for what purpose and to/from whom).

Treatment plan

Treatment plans come alive as therapeutic tools when practitioners discuss them with clients. The plan sets the stage, like a road map for the journey ahead. Mutual discussion of the individualized or team plan assures clients’ informed consent and collaboration. The plan includes the following:

- statement of problems, goals, treatment procedures, estimated duration of time needed to achieve goals;
- informed consent to assessment and treatment plan.

Ongoing progress notes

Progress notes also can be used as therapeutic tools with clients. They document what occurs during the treatment, especially whether clients are achieving the goals they identified in
their plans. Progress notes are part of the official record. Notes that are only of use to the practitioner who wrote them and not required for the official record are stored securely and shredded periodically to prevent confusion.

Progress notes can be brief, often only a paragraph. But they should show the focus of the session. Taking a few minutes immediately after every session to document is expedient, saves time and angst later, and ensures notes are legible, coherent, and contemporaneous. Here are essentials to include in progress notes:

- documentation from session to session regarding client’s concerns/issues/problems, response or lack of response to mutually agreed upon treatment;
- modifications of original treatment plan;
- discussion of any calculated risks taken by practitioner (e.g., rationale for controversial decisions, such as accepting a client’s invitation to a social event that could run the risk of crossing professional boundaries);
- follow-up notes on action/inaction related to earlier recommendations;
- reports to and from other professionals related to client’s counseling;
- correspondence related to work with client;
- documentation of client receiving or being denied health insurance payment for psychological services; any efforts the psychologist made to obtain or to appeal denial of insurance payment;
- telephone contacts from and to client;
- date of any modifications of records for accuracy;
- documentation of consultations with other professionals related to assessment and intervention (e.g., peer supervision on the case);
- documentation of informed consent to changes in mutually agreed-upon plan of action.

**Progress notes when working with groups, families, or teams**

In addition to maintaining a record to document progress of a group, family, or team, practitioners ensure privacy and confidentiality of individuals by simultaneously keeping separate records for individuals. Maintaining separate documentation in individual files requires a few extra minutes, but is the only way to guarantee adequate documentation and to protect each individual’s privacy and confidentiality. The following examples illustrate the different types of progress notes a sport psychologist created following her consultation to a team during which an individual team player shared problems that could possibly indicate a clinical depression. Note that none of the individual players’ names are cited in the team progress note.

**Example of a team progress note**

The focus of my session today with the women’s soccer team was on interpersonal tensions team players began feeling following the resignation of their former head coach two weeks ago, which the new coach and players felt were impeding team members’ abilities to focus and freely cooperate in the game. I helped them to clarify their concerns, which included anxiety over having differences of opinion regarding their previous coach; divided loyalty between old and new coach; fear of retaliation from previous coach; and should they be successful this season under the leadership of the new coach. We identified various strategies that could help the players let go of their worries in order to
focus on their play. We agreed to meet again next week to continue monitoring the team’s progress in handling the recent crisis.

Example of an individual progress note

Nancy, a sophomore player on the women’s soccer team, stated during my consultation to the team today that she was feeling overwhelmed by the team’s interpersonal tensions over the previous coach and his recent resignation. She felt grateful to the previous coach for her support during her first season last year. After the coach’s unexpected departure this fall, she felt anxious, began having difficulty sleeping and making more errors during games. She felt team players were wanting her to take sides, either “for or against” the previous coach. She felt anxious about forming a working relationship with the new coach. As I helped team members to clarify their respective feelings, Nancy said it dawned on her that the current situation felt reminiscent to how she’d felt following her parents’ conflicted divorce when she was four years old. I helped her to clarify in what ways the recent situation and previous conflicts she experienced during childhood were similar and different. I shared techniques to anchor one’s self in the present in order to relinquish feelings of responsibility and regain freedom to focus on play. I inquired but did not see indications of clinical depression in Nancy. My impression is that ongoing counseling to the team will be sufficient to help with her anxiety. However, I offered her and all team players individual appointments as needed in addition to my ongoing help to the team.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Assessment</th>
<th>Reasons (specific assessment criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DSM, IV, or ICD Code</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Date of Initial Evaluation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Problems</th>
<th>Goals</th>
<th>Treatment Procedures</th>
<th>Estimated Time For Tx</th>
<th>Progress</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

Therapist Signature:  
Client Signature:  

Figure 6.1 Treatment (Tx) plan.
For a sample treatment plan form that can be used as a therapeutic tool with clients, see Figure 6.1 (sections labeled “assessment” may be called “diagnosis”).

**Termination or closing summary**

Endings in counseling work are as important as beginnings (see Chapter 8). A closing summary that reviews the problems, treatment, progress or lack of progress, and how the work with the client ended, is indispensable. If clients return a month, or a year later, a closing summary helps us recall them and the earlier work together. It facilitates focus on the next phase of problems. When clients transfer to another therapist, a closing summary helps ensure continuity of care. When we receive requests for records from a third party, a closing summary makes it possible to encapsulate the minimum necessary information to achieve the goal of the request.

The closing summary can also be used as a therapeutic tool to benefit clients and to support the professional relationship. Few people have a chance to say what a professional counseling relationship has meant to them and to say goodbye. A chance to review the work together, including problems for which clients sought help, what clients and therapists did together, what clients experienced in therapy, and what they found helpful/not helpful aids in facilitating closure. Closure with one’s practitioners makes it easier in the future to seek help as needed. The following is how the psychologist can create a closing summary:

- document date and nature of ending (e.g., by mutual agreement, precipitously and unexpected);
- summarize brief descriptive information about client (e.g., athlete or team, reason/source of referral, original presenting problems, assessment and treatment, length of treatment, progress, outcome and status at closure).

For a sample of a closing summary form that can be used as a therapeutic tool with clients, see Figure 6.2.

**Inappropriate contents**

Some of the most common aspects of psychological work do not belong in the official record. These aspects include, for example, practitioners’ personal reactions in response to clients and complex feelings such as confusion, fragmentation, anger, or sexual attraction. Although understanding one’s own personal responses to individual clients is crucial for clarifying assessment or for preventing or ameliorating re-enactment of clients’ previous problematic relationships with significant persons in their lives – documenting such feelings in records may burden clients when they choose to read them. Practitioners can limit discussion of their own troubling personal feelings to their own external consultation or supervision. They can document they did so in a way that reflects they conscientiously sought help (e.g., “I obtained consultation to clarify my role within the professional relationship and the best intervention approach”). They can document in the record what they learned from supervision or consultation (e.g., “supervision clarified assessment and working relationship issues, including the need to set firmer limits with the client in our work together”).
Here are items to omit from records:

- personal reactions (in psychodynamic terms, these are countertransference feelings and thoughts);
- information not used to establish assessments or to conduct interventions;
- names of anyone who has not consented to receive services (e.g., clients’ friends);
- details about clients’ privileged communications with their attorneys;
- personal notes (notes understandable to, and meant only for, the practitioner, which are not part of the official clinical record, should be shredded periodically).

Considerations in how long to keep records

All psychology ethics codes address clients’ needs for continuity of care through maintenance of records and recommend that psychologists know their local legal responsibilities in determining how long to retain records (APA, 2007; APS, 2004; BPS, 2008). Some ethical guidelines specify how long to retain records (APS, 2007; APA 2007). See, for example, the Australian Psychological Society’s guidelines on record keeping that refer to
APS Code of Ethics, Section B2: “Members must make and keep adequate records for a minimum of seven years unless legal requirements specify otherwise. In the case of records collected while the client was a child, records should be retained at least until the individual attains the age of 25 years.”

How long to retain records beyond minimum requirements for retention can be difficult to answer. It can be helpful for various reasons to retain records indefinitely. Realistic considerations, however, such as storage space limitations, often preclude this luxury. For example, an athlete who received counseling from a sport psychologist 16 years ago due to troubles running related to a traumatic head injury, returned to the psychologist requesting help for anxiety learning to ski. His anxiety was re-surfacing at a new developmental stage in his life. Even though the psychologist retained the record well past her regulatory board’s record retention requirement, she now regretted shredding it for practical reasons during a recent office move. Although she recalled this former client and the focus of his previous therapy, not having his record made it more difficult to piece together some of the historical context. She worked collaboratively with the client in the initial interviews to refresh her memory and to clarify the client’s current needs.

Here are issues to consider when determining how long to keep records:

- Know your own setting’s regulations regarding length of retention of records for minors and adults.
- Consider clients’ needs for continuity of care.
- Consider statute of limitations in personal injury legal cases (for self-protection).
- In general, keeping adult records at least seven years post termination and minor children’s records seven years after age of majority is prudent practice.
- Have a consistent records destruction policy; never alter or destroy records with intent to avoid judicial proceedings.

Planning for interruptions or closures of practice

All mental health professions’ ethics codes include requirements for continuity of care in the event of interruptions or closures of practice (APA, 2007; APS, 2004; BPS, 2008). Nevertheless, many retired practitioners and the colleagues and spouses of deceased practitioners are unaware of their responsibilities to maintain and to manage records following their retirements or deaths (Luepker, 2003).

For professionals working within institutions, meeting ethical and legal requirements and protecting clients from adverse effects of abandonment can be easier when colleagues can assume care of clients and other administrative tasks in the event of practitioners’ illnesses, deaths, or other interruptions or closures of their practices. Solo practitioners, however, must proactively designate external colleagues who can agree to assume responsibility for their clients and to manage and maintain client records for the required length of time. Practitioners can help their clients by creating the following procedures:

- Communicate with clients about who will assume care as needed when the practitioner is unavailable.
- Ensure that another trusted practitioner has the means to gain access to client files, including names, addresses, phone numbers, and contact persons in case of emergency.
- When a practice closes permanently, notify current clients and help them make other arrangements for professional services as needed.
- Ask clients at termination regarding their wishes in the future to be notified should the practice close.
- When a practice closes permanently, make arrangements for secure storage and management of records for the duration of time required by law or professional ethics.
- Define the role and tasks of a designated colleague, which include but are not limited to the following: assume clinical work, attend to financial and clerical matters, monitor client billing and ensure up-to-date payments of bills, communicate with professional organizations and regulatory boards, negotiate contracts (or secure an attorney to do so), cancel subscriptions, work with the practitioner's attorney to dissolve the professional estate (in the event of the practitioner's death), respond to legitimate requests for access to clients' records.
- Provide a designated colleague with a professional directive regarding role and tasks and specific directions necessary to accomplish each task (e.g., how to change voice mail greeting, location of keys, list of subscriptions).

Conclusions

In closing, having knowledge about record keeping – its purposes, what to include, how to write records, how to plan for records in the event of interruptions or closure of practice – puts us in a strong position to protect ourselves and our clients. Using strategies such as outlines for our narratives and documenting evaluations and progress notes immediately after each session can help us to prevent problems later. But even when fortified with facts about competent record keeping, we can expect to sometimes fall short of our intentions. We can comfort ourselves by realizing that no practitioner writes perfect records. Good faith effort is what we can expect of ourselves. See Box 6.1 for practical take-home messages from this chapter.

Box 6.1

Practical take-home messages regarding record keeping

- All mental health organizations have codes of ethics that highlight the importance of protecting client welfare, including the need to appropriately document professional services.
- Few mental health organizations and regulatory bodies define and describe the characteristics involved in competent record keeping.
- Recently, increasing pressures for accountability challenge practitioners to obtain knowledge and specific methods in record keeping to protect themselves and their clients.
- Records form the basis of sound assessment and appropriate treatment plans.
- Records can become positive therapeutic tools, promoting communication about problems and strengths, enhancing mutual collaboration and trust in the working relationship between client and practitioner.
- Records are supervisory tools that facilitate a supervisor’s capacity to reflect on and support the learner’s work.
- Records satisfy contractual obligations and facilitate writing reports about clients.
- Records provide for continuity of care, allowing new practitioners to pick up where former practitioners ended.

**References**


