



Clinical Record Keeping: Breaking Out of the Circle

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The circle: Psychologists hear, from the Board of Psychology and elsewhere, that they must keep adequate records. So, they ask authorities what “adequate” means. The authorities refer them to standards established by the APA. And the APA standards say that psychologists, after carefully considering the issues, should pretty much decide for themselves.

This article looks at clinical record keeping in settings where the psychologist is not bound by employer or payor policy, and does so from the vantage of psychological ethics. Other kinds of records (forensic, research, training, etc.) and other vantages, such as legal, billing, and risk management, present different issues that won't be addressed here. The goal of this article is to summarize the rules psychologists must obey and the considerations that they must pay attention to, provide my own conclusions about what needs to be in a clinical record, and refer readers to the two essential sources, the APA Ethics Code and Record Keeping Guidelines (American Psychological Association, 2002, 2007).¹

Nobody likes keeping records. Moreover, once created, they pose some risk to patient privacy. Accordingly, no one will keep records unless she or he has reasons to. What are the ethical reasons?

The California Board of Psychology holds licensed psychologists to the APA Ethics Code. The Code says that psychologists must keep records to “facilitate provision of services later by them or by other professionals.” (Standard 6.01). This provision tells us that we must keep records sufficient to serve this purpose. Our profession's position is that records improve care provided later by the same psychologist, contrary to the view of some that records don't add significantly to their memory of the case.

There are other purposes that clinical records are called on to serve, such as defending against Board complaints, complying with payor or employer policies, and so on. The requirement to serve these other goals, though, comes from institutional policy or risk management needs rather than what one might call “pure ethics.”

What needs to be in a record to adequately serve this need? My focus, in the minimalist approach I'm taking here, is on the ethical need to facilitate later services. On this question, the Code is silent. The APA Record Keeping Guidelines, on the other hand, are specific

and detailed about what a psychologist “may consider” including. And how could one ethically not consider the most thoroughly vetted advice his or her discipline has to offer? The Guidelines suggest the following (APA, 2007, p. 996):

Information in the overall file: identifying data; contact information; fees and billing information; documentation of informed consent (required by APA Code 3.10); documentation of any mandated disclosure of confidential information (e.g., report of child abuse); presenting complaint, diagnosis, or basis for request for services; a plan for services, updated as appropriate (e.g., treatment plan); and, health and developmental history.²

For each substantive contact with a patient: date of service and duration of session; types of services (e.g., consultation, assessment, treatment, training); nature of professional intervention or contact (e.g., treatment modalities, referral, letters, e-mail, phone contacts); and, assessment of client status.

Additional information “depending upon the circumstances,” such as patient responses to interventions, current risk factors for harm to self or others, prognosis, plan, consultations, additional treatment modalities, and cultural factors.

As I look at this list from the point of view of my clinical practice, it is compelling. The items in it, one has to conclude, do accomplish the goal of facilitation of later services. If this information is in a record, another provider, or the same psychologist years later, would know: Why did the patient come? What is the patient's basic personal history? What was the psychologist's view about what approach would be helpful? What did the psychologist do, over how long a time, meeting how often? Did the services seem to help? How did the patient feel about the work? Were there any emergencies and, if so, did the psychologist's response succeed in addressing them? How did the services end, and was there a plan for further contact? At any given point along the way, if someone else needs to step in, the current status, particularly whether there are any current or recent emergencies, could readily be known.

So, the contents proposed by the Guidelines seem to me an excellent answer to the question of what a psychologist's records must contain (apart from their suggestion to specify for every contact the



