THE WETC PSYCHOLOGY NEWSLETTER

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Psychological Treatment Records: In Theory and in Practice, What Attorneys Should Expect

Treatment providers have both ethical and professional obligations to maintain complete and accurate treatment records of interactions with their patients. In the maintenance of these records, providers should keep in mind what information will be pertinent for upholding a high standard of care in their field and in their practice. For example, the Ethics Code for psychologists (American Psychological Association, 2002) specifies that the need to create and maintain records is based on assuring the quality of care, assisting other professionals involved in a patient's care with appropriate delivery of treatment, ensuring continuity of care in the event of a change of providers or the psychologist becoming otherwise incapacitated, providing continuity of professional services, supervising or training needs of personnel, documenting services for reimbursement purposes, documenting decisions and rationales for decisions in high-risk situations, and facilitating legal or regulatory proceedings. There may be variation in the level of detail provided by type of service and relevance to public disclosures (e.g., in some instances psychotherapy notes may be maintained separately from general records to allow for a higher legal protection of privacy), and there may be some exceptions to the keeping of full records, such as in the provision of care in emergency or disaster relief circumstances. Mental health care providers, however, should generally provide a minimum of the following information in their treatment notes:

- Dates of service
- Time spent in face-to-face encounter
- Type of therapeutic intervention (i.e. insight-oriented, supportive, behavior modification, interactive)
- Reported and observed symptoms and signs
- Progress toward achievement of treatment goals

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- Evaluation & Management services provided (e.g. medication management), including rationale for treatment decisions
- Diagnoses, if any
- Current plan, including referrals to other treatment providers
- Legible signature

Unfortunately, in practice, many mental health practitioners fail to create, keep, or supply such records appropriately, which can be problematic in the medical-legal setting for obvious reasons. In addition to keeping notes inclusive of the above information, by California law such records should be kept a minimum of 7 years following the date of service (in other states whose record-keeping laws are less stringent, they still must be held for at least 6 years according to federal law). The importance of documentation is not only an ethical and professional issue in the context of patient care, but a practical and legal issue in the context of medical-legal disputes or litigation. Ideally, progress and treatment notes furnish information for the court and retained medical examiner to answer questions such as:

- What has happened to the patient with regard to their psychiatric status, and do they have any verifiable diagnoses that are supported by documentation?
- How credible is the lawsuit?
- How credible is the therapist?
- Is the therapist following a treatment plan, and, if so, is the treatment effective and consistent with the disorder?
- Has the patient received sufficient treatment or do they need ongoing therapy?
- Was the therapist behaving in line with the scope of their license, e.g., in the case of a counselor or Marriage and Family Therapist?

In addition to the above, where relevant, information regarding clinical test results, functional status and prognosis may be appropriate. Even outside of medical-legal settings, patient report is an inadequate means of "documentation" and obtaining a complete and valid clinical and treatment history. This may not necessarily be related to his or her truthfulness in reporting the circumstances or sequelae of a contended injury. When it comes to commenting on their treatment, psychotherapy patients are like a blind man touching an elephant to perceive its form. What he or she perceives is not necessarily the whole picture. Thus, relatively little reliable and valid information can be obtained from a patient. However, the notes made by the doctor are quite different and very important with regard to making important decisions. Specifically, when they contain appropriate content and are written with appropriate level of detail and thoroughness, they tell the doctors, attorneys, and the court what was wrong with the patient, what the treatment provider did and whether or not the treatment was needed to cure or alleviate the injury that resulted in the litigation.

Other relevant information that may be gleaned by sufficiently maintained treatment notes, and that attorneys should look for and expect, are answers to the following types of questions: What should the records tell you? How open is the therapist? Is what appears in the notes the full story? If the patient is in group therapy, do there exist any tracking of their participation and progress? How was the termination handled? Was the therapist clear in saying they could be available for the standard 30 days after the termination, and were three referral names provided on termination? Were difficult issues handled ethically and professionally? Was the therapist in line with laws for reporting and functioning? Do the treatment notes correspond with the therapist's reports?

Finally, a word about psychotherapy notes. These notes are defined as "an official record, created for use by therapists, recorded in any medium… documenting or analyzing the contents of conversations during a private counseling session that are separated from the rest of the individual's medical record." (HIPAA, 2010). These can include information on the therapist's impressions about the patient, psychological processes, transference, dream analysis and personal history not immediately relevant to the patient's treatment plan. Such records are granted special protection under HIPAA due to sensitive information content, and because they are more for the therapist in formulating treatment interventions than for official progress tracking; thus they can be held from release. Other major, relevant progress and treatment information as described above, however, should be available and discoverable to facilitate efficient and accurate resolution of psychiatric or psychological injury-based litigation.

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