Documentation

A good record should contain the following:

1. Signed informed consents for all treatment
2. Signed informed consents for all transmission of confidential information
3. Any treatment contracts
4. Notation of all treatment contacts and significant information and actions regarding the contact (including face-to-face contacts with clients, client relatives, and others, and telephone contacts)
5. Notations of failed or cancelled appointments
6. Notations of supervision and consultation contacts
7. All correspondence and record of contacts with other professionals
8. A complete biopsychosocial history, including past and present evaluations and treatment, a medical history, and record of a current physical examination
9. A diagnostic assessment or statement, which should be reviewed, revised, and documented periodically
10. A list of all medications the person is currently taking
11. A record of the practitioner's basis for the assessment made and the treatment pro- vided
12. Notations of suggestions, instructions, referrals, or directives made to the client and whether they were followed
13. Risk assessment(s)
14. The practitioner's informal notes, including such items as speculation about client dynamics,
    a. impressions about the course of treatment,
    b. problems resolved,
    c. problems being worked on,
    d. problems to be worked on in the future,
    e. projections about termination, and
    f. summary of perceptions of significant treatment session dynamics
15. A treatment plan that is updated every ninety days, including
    a. client problems,
    b. short- and long-term goals (stated in observable and measurable form),
    c. notation of dates of achievement of goals, and
    d. signatures of client, therapist, and supervisor
16. Termination and referral

In many respects, the supervisory records may be integrated with the client records, and for legal purposes, significant supervisory contacts should be a part of the client record. Any payer requirements?

Supervisors' preferences vary. Supervisory records should include, at least,

1. the supervisory contract, if used or re- quired by the agency;
2. a brief statement of supervisee experience, training, and learning needs;
3. a summary of all performance evaluations;
4. notation of all supervisory sessions;
5. cancelled or missed sessions;
6. notation of cases discussed and significant decisions; and
7. significant problems encountered in the supervision and how they were resolved, or whether they remain unresolved and why.

Professional grievance hearing. Some supervisory relationships reach such a point, and it is difficult for the supervisor who is unable to document in a grievance how a supervisee's performance was unsatisfactory. The supervisor's memory and speculative recounting of the problems are insufficient. Supervisors who rely on their

memory are open to manipulation by difficult supervisees. If a grievance should result in a legal action, the courts often use the standard "If it is not written, then it did not happen" (Koocher, Norcross, and Hill, 1998). For this reason, thorough supervisory and treatment recording are important professional and legal safeguards.

The supervisory record should be a tool for promoting ongoing growth and development of the practitioner. Under the best conditions, it aids the supervisor in fostering professional growth of the practitioner. In difficult adversarial situations, the record is a documented defense against unrecognized and unaccepted practitioner failure in performance.