CHAPTER 12

Evaluation and Accountability

Dr. Flournoy: Hello, Ms. Wicks?

Ms. Wicks: Yes.

Dr. Flournoy: I am Dr. Flournoy from Children and Youth Services.

Ms. Wicks: Hello.

Dr. Flournoy: The Ramerez family has been referred to our service, and I understand that you have been working with Maria, here at school. I have requested that your counseling records be subpoenaed, and I simply wanted to let you know ahead of time, so that you could begin to get them in order.

Counseling records? Subpoenas? For some mental health practitioners the idea of maintaining records may be an anathema to the nature of the helping process. Further, the invitation to disclose these records as a result of a simple request, subpoena, or court order can arouse debilitating anxiety.

The need and ethical responsibility of keeping and maintaining records along with the inherent conflict that may exist when disclosure of these records is requested serves as the focus for the current chapter.

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● OBJECTIVES

The chapter will introduce you to the importance of maintaining records as both a measure of professional accountability and an essential step toward demonstrating ethical practice. After reading this chapter you should be able to do the following:

- Describe the benefits of utilizing a system of evaluation within one's practice
- Define the terms formative and summative evaluation
- Describe one approach to measuring outcome and goal achievement
- Identify the minimal records necessary for demonstrating competent, ethical practice

While it is true that no one professional can guarantee success in each and every encounter, the ethical practitioner will monitor services and adjust as required. Such a monitoring—or evaluation—be it through the informal collection of data or more formal forms, can offer direction and serve to demonstrate accountability. However, for some helpers, the concept of evaluation may be viewed as superfluous or tangential to the primary function of helping. While there is abundant evidence of the need for all mental health professionals to be able to demonstrate client progress and treatment effectiveness to the stakeholders they serve (Astramovich & Coker, 2007), the use of a well-developed system of practice assessment simply makes good practical sense. Such a system of assessment and accountability not only highlights the reality of the *terminal nature* of the professional relationship and provides a reference point for knowing when the process has achieved its desired end (i.e., summative evaluation), but it also provides markers to guide the process (i.e., formative evaluation) and thus ensure it remains on target for goal achievement. When viewed through the lens of accountability, to the client and the profession, an evaluation system becomes an essential ethical practice (see Table 12.1).

● MONITORING AND EVALUATING INTERVENTION EFFECTS

Evaluation is often thought of as something that is done at the end of a process. As suggested above, for evaluation to be prescriptive it needs to be ongoing and *formative* as well as *summative* in form.

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Table 12.1 Ethical Positions on Record Keeping

Professional Organization	*Position on Record Keeping*
American Counseling Association (2014)	B.6. Records and documentation a. Creating and maintaining records and documentation Counselors create and maintain records and documentation necessary for rendering professional services. b. Respect for confidentiality Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.
American Psychological Association (2010)	6.01. Documentation of professional and scientific work and maintenance of records Psychologists create, and to the extent the records are under control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analysis, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. 6.04. Maintenance, dissemination, and disposal of confidential records of professional and scientific work a. Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. b. If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not be consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers. c. Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.
American Association for Marriage and Family Therapy (2015)	2.5. Marriage and family therapists store, safeguard, and dispose of client records in ways that maintain confidentiality and in accord with applicable laws and professional standards.

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Table 12.1 (Continued)

Professional Organization	*Position on Record Keeping*
National Association of Social Workers (2008)	3.04. a. Social workers should take reasonable steps to ensure that documentation in records are accurate and reflective of services provided. b. Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of service provided to clients in the future. c. Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services. d. Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statues or relevant contracts.

Formative Evaluation

Formative evaluation is evaluation that occurs as an ongoing process throughout the helping encounter. It is the gathering of feedback and data used to expedite decision-making about the current process and the upcoming steps and procedures to be employed. It provides data that give form to the ongoing process. The means of collecting formative data can range in degree of formality. For example, a practitioner may choose to use a structured survey or questionnaire at various points in the helping encounter. Or more informally, the practitioner may simply set time aside to solicit feedback from the client about his or her experience in the relationship with the helper and the procedures employed up to this particular point (see Case Illustration 12.1).

Case Illustration 12.1

Formative Evaluation

Dr. Brown: First let me tell you how much I appreciate your openness and willingness to share with me some of your concerns about your social relationships and your desire

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	to become more assertive in these. I feel very comfortable working with you and feel that the things we have talked about in this first session have really helped us to clarify your goal and even begin developing a strategy for getting there. I think it may be helpful if we took a moment to share our perceptions on this session as a way of making future sessions more productive. I would be very interested in receiving your feedback about our session today.
Jim:	To be honest, I was very nervous when I made the appointment. However, I am really surprised how much I shared. I really feel like I can trust you. I feel very comfortable speaking with you, and that is not my style, usually.
Dr. Brown:	Well, that is very nice to hear, and I know from what you told me that you tend to be a private person. Jim, as you are aware, we will probably want to talk more about your family background and previous relationships as our sessions go on. How do you feel about that? (Dr. Brown checks Jim's understanding of the helping process.)
Jim:	I know that probably needs to be done. It makes me a little anxious, but as I said, I do feel comfortable with you and trust you, especially how you explained the idea of confidentiality, I just may need to go slow.
Dr. Brown:	That's good feedback for me. The pace of the sessions really will be the one that feels right for you. So if we need to go slow, we will. If you want to dive into something and it seems right to me, we will. I think as long as we continue to "process" how we are doing, we can make sure we stay on track at a pace which is both productive and comfortable. (Dr. Brown checks Jim's comfort level and takes direction.)
Jim:	Yeah, me too.
Dr. Brown:	So, while overall you are hoping to get some help with developing assertiveness skills, our immediate goal is for you to take notes on two incidents: one in which you felt you were assertive and one in which you felt

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	very unassertive. Are these the goals we agreed on? (Dr. Brown checks agreement on goals.)
Jim:	Yes, that's exactly what I want to do . . . get more assertive! And I like the idea of doing some "research work" for our next session.

For this evaluation to truly form and give shape to the decision-making processes, it should begin with the first session. As evident in Case Illustration 12.1, the helper engaged in formative evaluation within the first session. The approach taken by this helper provided insight into the client's level of comfort with the interaction and his ability to engage collaboratively in the helping process. This evaluation also served as a check on the accuracy of the helper's understanding regarding the desired goals and outcome for the helping process. The use of such a formative evaluation not only provides for helper accountability but also provides the data for monitoring and increasing efficacy of treatment.

Summative Evaluation

Summative evaluation is the type of evaluation most typically thought of when considering goal or outcome assessment. The specific purpose of summative evaluation is to demonstrate that the action plan has reached its original objective. Summative evaluation provides the helper and the client data to determine (a) if the original goals were achieved, (b) the factors that contributed to this goal attainment, and (c) maybe even the value of this strategy versus some alternative. The articulation of clear treatment goals and the employment of summative evaluation strategies serve as invaluable sources for demonstrating treatment efficacy and helper accountability.

The presence of clearly articulated goals or outcomes is essential for both formative and summative forms of evaluation. Without a clear, shared vision of where the helping process is going, it will be hard to know if it is on track or even if it has arrived. Thus, the establishment of treatment goals and objectives, the identification of outcome measures, and the maintenance of appropriate responsible records serve as keystones to ethical and efficient practice.

Setting Treatment Goals and Objectives

While it may seem obvious that the counseling relationship and process is neither totally open ended nor aimless, as a professional encounter, our helping

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is both intentional and directional. To be effective, it is essential that the helper, along with the client, identifies and clarifies client needs and desired goals. Research (e.g., Seijts, Latham, Tasa, & Latham, 2004) has demonstrated that the articulation of goals is essential to the problem-solving process. However, to be effective, these goals cannot be vague, overly generalized, or unrealistic. As such, it is suggested that the effective, ethical practitioner will help the client to set goals that are specific, measureable, attainable, relevant, and time bound (Parsons & Zhang, 2014). Such goals may be identified with the acronym SMART goals. Taking these into consideration for one's own practice, the questions posed in Table 12.2 will be helpful in the development of these goals.

Table 12.2 Developing SMART Goals

Goal Characteristics	*Questions to Guide Goal Setting*
Specific	Does the goal outline exactly what you are trying to achieve?
Measurable	How will you know if progress is being made? How will others know if progress is being made? Is the progress quantifiable?
Attainable	What resources do you need to achieve this goal? Can the goal be achieved independently? Is the goal too big? If so, can the goal be broken down into smaller SMART goals? What factors or forces exist that could interfere with the achievement of the goal? What is the plan to remove or navigate these forces?
Relevant	How important to you is this goal? What are the positive consequences of achieving this goal? How will achieving this goal affect your personal and professional life?
Time Bound	Have you set a target date? Can you establish benchmarks along the way to use as evidence of progress? Is the timeline reasonable? Flexible?

Source: Adapted from Zhang & Parsons (2016). *Field experience: Transitioning from student to professional.* SAGE Publications, Thousand Oaks: CA.

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Measuring Outcome and Goal Achievement

The selection of appropriate outcome measures is far from easy. Clinicians recognize that the helping process, when effective, can reveal itself in many ways—even beyond the achievement of the terminal goal. For example, while attempting to help a client cope with his social anxiety it may not be unusual to find that the client exits the relationship with a better sense of his own vocational calling or insight into his current relationships or even a desire to pursue additional growth-oriented counseling. Using more than one outcome and outcome measure increases the probability of accurately depicting the entirety of the experience. At the most fundamental level, the practitioner can assume that one outcome reflects the nature of the presenting concern. For example, if a clinician is interested in ameliorating a presenting complaint, the nature of that complaint (e.g., test anxiety, marital dissatisfaction, depression, etc.) provides direction to the outcomes desired. After targeting the general area in which the helper expects to demonstrate impact (i.e., reduce test anxiety, increase achievement level, etc.), that particular area needs to be clearly and concretely defined. It is important to realize that while there will be a primary focus for the assessing outcome (e.g., reduce the amount of client depression or increase student attention, etc.), these targets may be manifested in a number of different ways and occur within a unique context. The more perspectives we take on the outcome and the more measures we employ, the greater the chance we have of understanding the nature and depth of impact our practice may have produced. Consider the approach taken by the helper illustrated in the following case (Case Illustration 12.2).

Case Illustration 12.2

Assessing Outcomes of Treatment With Depressed Client

Alicia came to therapy because of a "constant" feeling of sadness and an inability to get motivated about anything in her life. At the initial meeting with Alicia, Dr. Warrick attempted to identify the various ways in which her feelings of sadness were experienced and were impacting her life.

Dr. Warrick: Alicia, you have mentioned that you are not "doing anything" and you can't get motivated. Could you tell me more about that?

Alicia: Well, I have a lot of school work that should be done, and each time I sit down to do it I think, why bother,

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nothing is going to come out, and then I walk away from the computer and get something to eat or go to bed.

Dr. Warrick: So it seems that you not only feel sad, at times, but you also have this belief that "nothing is going to work"?

Alicia: That's right! And it is not just with school stuff. If I get a call from a friend I typically go out with, I think, why bother going out, it is not going to help. And I stay home.

Dr. Warrick: So one of the things that we may watch as we work together isn't just your feelings of sadness but also the frequency of this, why bother, it's hopeless thinking?

Alicia: I don't want to feel sad anymore, but I also understand what you mean about the thinking.

Dr. Warrick: You also seem to suggest that when you are feeling this way, you avoid your friends and avoid engaging in activities (like school work)?

Alicia: Yeah, I have not seen my friends in weeks. I'm sure they are annoyed. And I don't even do housework anymore. My place is a mess.

Dr. Warrick: Well, Alicia, I appreciate how open you have been with me today, and I truly feel we have taken a good step toward helping you to feel and behave the way you want to. As we continue working together, we will not only keep our eyes on your feelings of sadness with the intent of gaining some relief, but we will see if there is an increase in the frequency with which you go out with your friends or do house chores and school work. Further, we will hopefully also see a change in your thinking. Rather than thinking why bother thoughts, we will see more productive thoughts. How does that sound?

Alicia: It sounds like a lot and I'm not sure that we can do this. Wow, there is that why bother thought again!

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But, if I would start feeling and thinking and acting differently, then I would not need to be here.

Dr. Warrick: That's good! I like the way you already attacked that thought of yours!

While most individuals recognize depression to be a mood, an affect, or a feeling, depression also manifests itself in a person's behavior, thought processes, and interpersonal interactions. A helper, like Dr. Warrick (see Case Illustration 12.2), who may be attempting to assess the effectiveness of a particular medication or treatment approach on depression, should assess changes not only in the client's mood but also in the client's behavior (e.g., doing school work), thought processes (e.g., having less frequent thoughts of suicide or thoughts of why bother), and interpersonal interactions (e.g., beginning to reengage with family and friends), along with gathering information about how the client feels about these changes.

Table 12.3 provides one useful way for conceptualizing the various domains in which interventions may impact the client. It is useful to consider gathering data in many, if not all, of these domains in an attempt to accurately evaluate the impact of practice decisions. The listing presented is an adaptation of the work of Arnold Lazarus (1989). The essence of this model is the belief that a person's functioning or dysfunctioning is manifested along seven modalities: behavior, affect, sensation, images, cognition, interpersonal relationships, and biology/physiology. Lazarus represented these seven domains with the acronym BASIC ID. Using each of these components as a reference point, the helper can conceptualize the impacts of his or her practice more broadly.

Table 12.3 presents three dimensions for consideration when identifying outcomes to action research. First, modality refers to the specific arena in which this construct may be manifested (i.e., BASIC ID). The second dimension, manifestation, is the place where the practitioner identifies the manner or form in which this particular target of the investigation appears. The final column, data collection techniques, identifies the types of techniques that can be useful when assessing that domain. It should be noted that while a specific method of data collection has been identified in Table 12.3, other methods may work as well.

Exercise 12.1 provides an opportunity to employ to this approach with a problem of your choosing.

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Table 12.3 Classification Scheme for Outcome Measures: Using an Example of a Client

Experiencing Anxiety in Social Settings		
Modality	*Manifestation*	*Sample Methods of Data Collection*
Behavior	Withdraws from social contact	Observation
Affect	Anxious	Survey (anxiety checklist)
Sensation	Muscle tension	Self-report (journal)
Imagery	Dreams about being abandoned	Self-report (journal)
Cognition	Believes he has no right to say no	Assertiveness questionnaire
Interpersonal	Withdraws and fails to maintain eye contact	Observation, interview peers
Drugs/Biology	Stomach upset/blood pressure high	Self-report and blood pressure recordings

Exercise 12.1

Identifying Personal Outcomes

Directions: Below are a number of general statements about personal improvement and growth. Select one that may be of interest to you and using the table below, identify the various manifestations of this goal achievement along with techniques for assessment.

- Become a better student
- Become more social
- Become more spiritual
- Improve general health

Modality	*Definition*	*Sample Methods of Data Collection*
Behavior		
Affect		

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Modality	*Definition*	*Sample Methods of Data Collection*
Sensations		
Imagery		
Cognition		
Interpersonal		
Drugs		

Record Keeping

Record keeping is important not just to document service but also to guide and direct the practitioner in his or her practice decisions. Accurate, complete records can, for example, allow a practitioner to review the therapeutic process and thus foster self-monitoring on the part of the practitioner. Thus, implicit within the discussion of evaluation and outcome measurement is the understanding that data will be collected and recorded for later analysis. These data can be of various forms, including test scores, clinician observations, and notations. In whatever form they are, these data constitute a client's record and must be handled with sensitivity.

Maintaining thorough records and clinical notes is essential to the planning and monitoring of services as well as to providing data, should the interaction ever be questioned as in the case of a lawsuit. Keeping good and accurate records provides a strong foundation for counselors in the event of claims regarding legal issues and ethics violations (Mitchell, 2007). Thus, even with concern about possible requirements to disclose, experiences of inconvenience, or a practitioner's belief in the power of his or her memory, the ethical practitioner will collect and maintain useful professional records. In fact, all of the professional organizations (see Table 12.1) call for the ethical collection, maintenance, and dissemination of client information.

Nature and Extent of Records

Records should document the nature, delivery, and progress of services provided. Additional information may be required by state statute and/or

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contract, as when services are provided as part of a managed care organization. While the specifics of what may be required as part of a client's record varies from state to state, generally it is important to maintain a legible record that includes at a minimum the following: identifying data; dates of services; types of services; fees; any assessment, plan for intervention, consultation, and/or summary reports as may be appropriate; and any release of information obtained. One example of the types of records one should maintain was developed by the Committee on Professional Practice and Standards of the APA. While the model is somewhat dated it remains a useful guide for practitioners. This committee adopted a set of guidelines (see Canter, Bennett, Jones, & Nagy, 1994), which suggests that at a minimum records should contain the following:

- Intake sheet, including client identifying information
- Documentation of a mental status assessment
- Signed informed consent
- Treatment plans
- Psychological tests
- Documentation of referrals
- Types of services provided
- Appointment dates and times
- Release of information
- Discharge summary

While the above provides some minimal guidelines for identifying the nature and type of records to be collected and maintained, the specific form of each of the above or the nature and content and style of clinical notes and records will be determined by the specific regulations of the setting in which the services are provided, state laws, or helper preferences (see Exercise 12.2).

Exercise 12.2

Nature of Records to be Kept

Directions: Using the questions listed below, interview two professional helpers in each of the following professions:

- Private practitioner
- School counselor
- Criminal justice worker/counselor

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- Drug and alcohol counselor
- Marriage therapist

Ask each helper if he or she keeps client files and if not, why not. If yes, ask him or her

- What type of information do you keep in your files?
- How long do you maintain your files?
- Does your client have access to these files?
- Have you had your records subpoenaed? If so, what was your response?

Compare and contrast the helpers' responses. Was there commonality within the specific helping profession? What similarities or differences existed across professional groups?

Regardless of the types of data collected, clarity and utility should guide the process. The notes are meant to assist in the treatment (utility), and since records belong to the client and copies could be requested, they should be clearly written in a manner that is honest and non-demeaning.

Storage and Access

The collection and maintenance of such sensitive information can conflict with a client's right to personal privacy if not handled professionally and ethically. For example, the American Psychological Association's ethical code (2010), Principle 6.02 (a) states, "Psychologists maintain confidentiality in creating, storing, accessing, transferring and disposing of records under their control, whether these are written, automated, or in any other medium."

There is, however, no one set of standards that concretely and universally applies across professions and settings. It is incumbent for each professional to understand the ethical principles articulated within his or her profession. In addition to these standards, the practitioner needs to be aware of the legal statutes and practice principles governing the acquisition, storage, and maintenance of records in his or her own particular setting. For example, practitioners working within a school setting that receives federal

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funding will be governed by the Family Educational Rights and Privacy Act (FERPA) (U.S. Department of Education. 2015). This act provides rights of access to educational records to students and their parents and defines educational record as any record kept by employees of the educational institution. Since broad access of records is not required of practitioners working within a non-federally funded setting, it is clear that the decisions regarding the nature of records collected and the forms of storage can vary setting to setting.

In what is now a significant event in the history of educational record keeping, the Russell Sage Foundation convened a conference in 1969 of representatives from educational and legal institutions as well as experts in related fields to address the issue of collecting, maintaining, and disseminating records within the schools. The members concluded that "current practices of schools and school personnel relating to the collection, maintenance, use and dissemination of information about pupils threaten a desirable balance between the individual's right to privacy and the school's stated 'need to know'" (Russell Sage Foundation, 1970). The outcome of this conference was the production of a proposed set of guidelines that, while targeted to pupil records, has value for all practitioners, regardless of the setting and the population with whom they work. A number of points gleaned from the historic conference are presented in and serve as a reference point for Exercise 12.3.

Table 12.4 Summary of Russell Sage Conference

Collection of Data	*Consent*	*No information should be collected without prior informed consent.*
		The client should be informed as fully as possible, consonant with the practitioner's professional responsibility and the capacity of the client to understand.
		Even when data is collected under conditions of anonymity, the obligation to obtain consent remains.
Maintenance of Data	Levels: Category A	Data included here reflect the minimum personal data necessary (e.g., name, address, date of birth, academic background, etc.).
		For schools, these data should be maintained in perpetuity.

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Table 12.4 (Continued)

Collection of Data	*Consent*	*No information should be collected without prior informed consent.*
	Category B	Data are of clear importance but not absolutely necessary for helping the client or protecting others over time (e.g., scores on standardized testing, family background data, observations and rating scales).
		These data (in regard to school settings) should be eliminated as unnecessary at periodic intervals (e.g., transition points, such as moving from elementary to junior high).
	Category C	This is useful information needed for the immediate present (e.g., legal or clinical findings).
		Data should be reviewed at least once a year (in school settings) and destroyed as soon as their usefulness is ended. If usefulness continues and validity of information has been verified, they may be transferred to Category B.
	Confidential, personal files	Any and all data that are considered personal property of the professional should be guarded by the rules given above and dictated by professional ethics, terms of employment, and any special agreements made between the professional and the client.
Dissemination	Releasing without consent	In school setting, category A and B data may be released to other school officials including teachers who have a legitimate educational interest in pupil records.
	With consent/ judicial order	School may not divulge any information to anyone outside of the legitimate school personnel without written consent or compliance with judicial order.
	Non-release	Under no conditions, except court order, should school release information in Category C.

Source: Adapted from *Guidelines for the Collection, Maintenance and Dissemination of Pupil Records. Report of a Conference on the Ethical and Legal Aspects of School Record Keeping* (1969). © Russell Sage Foundation, 112 East 64th Street, New York, NY 10065. Reprinted with Permission.

Database and Computer Storage

The issue of storage and access takes on special significance when considered within the advances of this technological era and the use of

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Exercise 12.3

Assessing School Record Keeping

Directions:

Step 1: Contact your high school or a local high school. Inquire what their policy is regarding the gathering, maintenance, access, and disposal of the following types of records:

- Student attendance
- Student course grades
- Student discipline record
- Student health records
- Student standardized test scores
- Student counseling records (if any)
- Student Individualized Education Plan (IEPs) or specialized academic program plans
- Teacher, counselor, administrator anecdotal notes on students

Step 2: Using the category breakdown listed in Table 12.4 (Russell Sage Foundation, 1970), evaluate the degree to which this school is following the Russell Sage guidelines.

computers for database storage. For example, the American Psychological Association's ethical code describes the situation: "If confidential information concerning recipients of psychological services is to be entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers" (APA, 2010, 6.02 [b]).

RECENT LEGAL DECISIONS ●

One area of professional practice that has recently been impacted by court decisions is in regard to a client's right to access psychiatric records. The federal Freedom of Information Act of 1966 and various state patients' rights laws often specify client right to access certain personal records. While mental health records have previously been exempted from this policy, the trend appears to be reversing in favor of client access.

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For example, it was initially successfully argued that such free access could result in harm to a client, that sharing technical information with clients who are not equipped to understand or deal with this information may prove counterproductive and/or harmful. This argument found support in the case of *Godkin v. Miller* (1975). Janet Godkin had been a voluntary patient at three different New York hospitals. Later, she and her husband decided to write about the experience and requested access to her records. Her requests were denied. In her lawsuit against the New York State Commissioner of Mental Hygiene and the directors of the hospital, the court ruled that the refusal was warranted in light of the fact that the hospitals stated a preference to release the information to another professional. There are a number of points in the process of record acquisition, storage, maintenance, access, and disposition in which a practitioner may be confronted with ethical and or legal questions. However, the courts have not provided a clear directive covering all of these aspects. Without clear legal direction, it is important for practitioners to adhere to commonly held and customary practices and those reflecting their specific codes of ethics. As such it is important to keep the following in mind when keeping records:

1. Ensure that all records and documentation be kept in secure locations where unauthorized access is denied (e.g., ACA, 2014, Principle B.6.b).
2. Write notes in nontechnical, clear, and objective statements with behavioral descriptions. Subjective or evaluative statements involving professional judgments should be designated as such and written in a separate section clearly set aside from factual content. Many practitioners use the S.O.A.P. (subjective, objective, assessment, and plan) format for note taking (Cameron, & Turtle-Song, 2002).
3. All client records should be written with the understanding that they might be seen by the client, a court, or some other authorized person, who may refer to the notes for continuity of care (e.g., see APA, 2010, Principle 6.01).
4. Realizing the purposes for which we maintain records, only information that is necessary for documenting that which was done and directing that which should be or will be done, should be recorded. The American Counseling Association, for example, is clear in stating that its members "include sufficient and timely documentation to facilitate the delivery and continuity of services" and "ensure that documentation accurately reflects client progress and services provided" (ACA, 2014, Principle A1.b).

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CONCLUDING CASE ILLUSTRATION ●

The scenario that opened this chapter highlighted the importance of record keeping and the potential that such records may be requested. As we continue the scene, however, we will see that it also raises a number of issues regarding (a) the types of information one collects; (b) the way that records are maintained, and (c) the questions of access to records.

Dr. Flournoy: Hello, Ms. Wicks?

Ms. Wicks: Yes?

Dr. Flournoy: I am Dr. Flournoy from Children and Youth Services.

Ms. Wicks: Hello.

Dr. Flournoy: The Ramerez family has been referred to our service, and I understand that you have been working with Maria, here at school. I have requested that your counseling records be subpoenaed, and I simply wanted to let you know ahead of time, so that you could begin to get them in order.

Ms. Wicks: I appreciate your notification. Even though we utilize computerized intake forms, inventories, and counseling notes, it is always nice to have some lead time to get them together. As I am sure you are aware, I will need a copy of the Release of Information and I would like one from Maria, in addition to her parents.

Dr. Flournoy: I understand that you would like a release, and actually I brought copies of both a parent release and the client's signed release. You can keep them for your records. You mentioned that you have intake forms, inventories, and client notes with computer access.

Ms. Wicks: Yes.

Dr. Flournoy: Well, I'm going to ask for all the notes, including your professional observations and anecdotal notes.

Ms. Wicks: Well, Dr. Flournoy, the school's policy is that counselor records include

- Intake sheet, including client identifying information
- Signed informed consent
- Documentation of referrals
- Types of services provided

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- Standardized test scores and/or inventories employed
- Appointment record
- Release of information
- Summary of contact

So I will be happy to provide these to you.

Dr. Flournoy: Thank you. But I know as a counselor you probably kept personal notes. I would like to see those as well.

Ms. Wicks: The notes that we have are those identified by school policy. I've already listed those and I will be glad to provide them. But first, I do want to speak with Maria, and even though she signed the release, I would like her to know exactly what we will be releasing.

Reflections

1. What do you think about Ms. Wicks's request for a release of information from both the parents and Maria? Was it legally required? Ethically required?
2. Ms. Wicks outlined the type of information that the school directed counselors to maintain. How adequate do these records appear to be? Is there anything you feel is missing?
3. What concerns would you have with having this data in computer storage?
4. What is your reaction to Ms. Wicks's response in regard to personal, anecdotal notes?
5. Ms. Wicks noted that she wanted to explain to Maria the types of material to be released. Was that necessary? Required? What are your feelings regarding that decision?

● COOPERATIVE LEARNING EXERCISE

As with all of the previous cooperative learning exercises, the current exercise is designed to help you personalize the material and begin to move your understanding to professional practice. Working with a colleague and/or

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classmate, identify the types of client information that you feel are needed in the course of your professional practice and that will be retained within a client record. Next, complete the following:

- Design samples of the specific forms or data collection tools you will employ.
- Contact three individuals currently working in the area of professional practice that you envision doing and request copies of their data collection tools and instruments.
- Finally, contact your state association and inquire about the length of time you will be responsible for maintaining these records.

SUMMARY ●

- Evaluation of the helping process needs to be ongoing and formative as well as summative in form. Formative evaluation is evaluation that occurs as an ongoing process throughout the helping encounter. Summative evaluation is the type of evaluation most typically thought of when considering goal or outcome assessment.
- Because of the potential to influence the client and the client's ability to formulate his or her own goals and objectives, it is important for the practitioner to be sure to engage the client in terminal goal formulation.
- When articulating treatment goals, the more perspectives we take on the outcome and the more measures we employ, the greater the chance we have of understanding the nature and depth of impact our practice may have produced.
- Record keeping is important not just as a documentation of service but also to guide and direct the practitioner in his or her practice decisions.
- Maintaining thorough records and clinical notes is essential to the planning and monitoring of services as well as to providing data should the interaction ever be questioned, as in the case of a lawsuit.
- Records should document the nature, delivery, and progress of services provided. The collection and maintenance of such sensitive information can conflict with a client's right to personal privacy if not handled professionally and ethically.

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IMPORTANT TERMS

accountability

data collection techniques

evaluation

Family Educational and Privacy Act (FERPA)

formative

modality

outcome measures

record keeping

Russell Sage guidelines

summative

terminal goal

ADDITIONAL RESOURCES

Print

American Psychological Association. (2007). Record keeping guidelines. *American Psychologist, 62*(9), 993–1004.

Christiansen, R. (2012*). Zig zag principle: The goal setting strategy that will revolutionize your business and life*. New York, NY: McGraw-Hill.

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Johnson, V. (2010, February 16). *Jim Rohn setting goals part 1* [Video file]. Retrieved from www.youtube.com/watch?v=YuObJcgfSQA

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